

CARE SERVICES PROGRAM ADMINISTRATIVE MANUAL



January 2005

Office of AIDS
Department of Health Services
State of California



Chapter 1

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MANAGEMENT MEMOS

The Office of AIDS (OA) is pleased to provide you with a copy of the Care Services Program (CSP) Administrative Manual. This tool was developed in response to requests for information focused specifically on the administrative requirements, both federal and state, that pertain to the Title II funded Care Services Program. In addition, this manual provides updated programmatic information regarding the Comprehensive AIDS Resources Emergency (CARE) Act Amendments of 2000, that emphasizes access to primary medical care for all populations.

We hope this manual will provide you with the technical assistance needed for administration of your CSP. If you require further clarification or technical assistance, your CSP Advisor is available to assist you. See Exhibit 3 for a list of advisors and CSP assignments.

**USE OF THE CARE
SERVICES PROGRAM
ADMINISTRATIVE
MANUAL**

The CSP Administrative Manual has been prepared to assist Fiscal Agents and service providers in understanding the administrative requirements of the CSP. In addition, the Administrative Manual provides example forms that may be used in the administration of the CSP.

Certain CSP requirements pertain only to specific eligible uses of the funds. Where requirements are specific only to certain activities, it is noted within the Administrative Manual.

You may download this manual from the Office of AIDS web site, www.dhs.ca.gov/aids. Updates to the Administrative Manual will be posted periodically. The OA recommends that all parties responsible for the administration of CSP funds become familiar with the information contained within this Administrative Manual.

**CARE SERVICES
PROGRAM LEGISLATION**

In August 1990, Congress enacted Public Law 101-381, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to improve the quality and availability of care for people with HIV/AIDS and their families. Amended and reauthorized in May 1996 and October 2000, the Act is named after the Indiana teenager, Ryan White, who became an active public educator on HIV/AIDS after he contracted the syndrome. He died the same year the legislation was passed.

This Administrative Manual reflects the requirements as cited in the CARE Act and subsequent reauthorizations.

The CARE Act legislation is included in this manual as Exhibit 1. Copies of the Act and reauthorizations are available on the Health Resources and Services Administration (HRSA) website, www.hab.hrsa.gov/law.htm.

**THE HEALTH
RESOURCES AND
SERVICES
ADMINISTRATION
(HRSA)**

The mission of the Health Resources and Services Administration (HRSA) is to improve the nation's health by assuring equitable access to comprehensive quality health care. HRSA has established five long-range strategies in support of its mission. They are:

- Strategy I: Reduce Barriers to Care
- Strategy II: Reduce Health Disparities
- Strategy III: Improve Quality of Care
- Strategy IV: Strengthen Public Health and Health Care Access
- Strategy V: Improve the Emergency Preparedness of the Health Care System

**THE HIV/AIDS BUREAU
(HAB)**

The HIV/AIDS Bureau (HAB) of HRSA was formed in August 1997 to consolidate all programs funded under the CARE Act.

In serving people and families affected by HIV/AIDS, HAB, headed by HRSA Associate Administrator Deborah Parham, Ph.D., R.N., has identified four factors that have significant implications for HIV/AIDS care, services, and treatment:

1. The HIV/AIDS epidemic is growing among traditionally underserved and hard-to-reach populations.
2. The quality of emerging HIV/AIDS therapies can make a difference in the lives of people living with HIV.
3. Changes in the economics of health care are affecting the HIV/AIDS care network.
4. Policy and funding increasingly are determined by outcomes.

**HRSA AND HAB POLICY
MEMOS**

HRSA, through HAB, administers all Titles of the CARE Act. The OA receives Policy Memos from HRSA and HAB. Memos that directly affect the CSP are forwarded to the Fiscal Agent via a CSP Management Memo.

**CSP MANAGEMENT
MEMOS**

CSP Management Memos (MMs) are distributed by OA periodically. They provide additional information and clarification regarding administration and use of CSP. MMs may also request information or acknowledgement of program compliance within a limited time frame. It is VERY important that Fiscal Agents and/or service providers are cognizant of these time frames and respond by the requested due date.

It is recommended that CSP MMs be retained with this manual and updated as necessary.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is federal legislation that addresses the unmet health needs of persons living with HIV disease (PLWH) by funding primary health care and support services that enhance access to and retention in care. First enacted by Congress in 1990, the CARE Act was amended and reauthorized in 1996 and again in 2000 and is due for reauthorization in 2005. The CARE Act reaches over 500,000 individuals each year, making it the Federal Government's largest program specifically for people living with HIV disease.

Like many health problems, HIV disease disproportionately strikes people in poverty, racial/ethnic populations, and others who are underserved by healthcare and prevention systems. HIV often leads to poverty due to costly healthcare or an inability to work that is often accompanied by a loss of employer-related health insurance. CARE Act-funded programs are the "payer of last resort." They fill gaps in care not covered by other resources. Users of CARE Act services usually include people with no other source of healthcare and those with Medicaid or private insurance whose care needs are not being met.

CARE Act services are intended to reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life for those affected by the epidemic. The CARE Act works toward these goals by funding local and state programs that provide primary medical care and support services, healthcare provider training, and technical assistance to help funded programs address implementation and emerging HIV care issues.

The CARE Act provides for significant local and state control of HIV/AIDS healthcare planning and service delivery. This has led to many innovative and practical approaches to the delivery of care for PLWH. The Act directs assistance through the following channels:

Title I

Eligible Metropolitan Areas (EMAs) with the largest numbers of reported cases of AIDS, receive funds to meet emergency service needs of people living with HIV disease. EMAs are administered and funded directly by HRSA through county health departments. Fifteen counties in California are included in the following nine EMAs:

- Inland Empire (Riverside and San Bernardino)
- Los Angeles
- Oakland (Alameda and Contra Costa)
- Orange
- Sacramento (Alpine, Placer, El Dorado, Sacramento)
- San Diego
- San Francisco (Marin, San Francisco, San Mateo)

- Santa Clara
- Sonoma

Title II

All states, the District of Columbia, Puerto Rico, and eligible U.S. territories receive funds to improve the quality, availability, and organization of health care and support services for individuals living with HIV disease and their families. The California Department of Health Services, Office of AIDS (OA) oversees the implementation and funding for Title II of the Ryan White CARE Act.

Title III

Public and private nonprofit entities receive funds to support outpatient early intervention HIV services for PLWH. Title III is directly administered and funded by HRSA.

Title IV

Public and private nonprofit entities receive funds for projects to coordinate services and provide enhanced access to research for children, youth, women, and families with HIV/AIDS. Title IV is directly administered and funded by HRSA.

**Part F –
DEMONSTRATION AND
TRAINING**

**Special Projects of
National Significance
(SPNS)**

The SPNS Program advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection. SPNS grants fund innovative models of care and support the development of effective delivery systems for HIV care. The SPNS Program is considered the research and development arm of the Ryan White CARE Act and provides the mechanisms to:

1. assess the effectiveness of particular models of care
2. support innovative program design
3. promote replication of effective models

**The AIDS Education and
Training Centers (AETCs)**

The AETCs Program is a network of 11 regional centers (and more than 70 associated sites) that train health care providers to treat persons with HIV/AIDS. The AETCs serve all 50 states, the District of Columbia, the Virgin Islands, Puerto Rico, and the six U.S. Pacific Jurisdictions. The AETCs Program has trained over 700,000 health care providers. The program's goal is to increase the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage individuals with HIV infection and to help prevent high risk behaviors that lead to HIV transmission.

Part F is directly administered and funded by HRSA.

CARE ACT FACT SHEET

Please see Exhibit 11 for a copy of the Title II Ryan White CARE Act fact sheet.

**RYAN WHITE CARE ACT
PURPOSE AND GOALS**

The CARE Act is:

- A major federal program specifically designed to address gaps in care for PLWH
- A source of funds for primary health care and support services that enhance access to and retention in HIV/AIDS care

Goals

- Reduce the use of more costly inpatient care
- Increase access to care for underserved populations
- Improve quality of life for those affected by the epidemic

Need for the CARE Act

HIV disproportionately strikes people in poverty, racial/ethnic minority populations, and other individuals who are underserved by health prevention and care systems.

- HIV often leads to poverty

- CARE Act is the "payer of last resort"
- Programs serve people with no regular source of health care and people with Medicaid or private insurance whose HIV-related care needs are not being met by other providers

Approach

- Primarily grants to local and state programs to provide primary medical care and support services, health care provider training, and technical assistance to funded programs
- Funds support services that enhance access to and retention in care
- Provides for significant local and state control of planning and service delivery
- Provides limited funds for administration, including planning, quality management, and evaluation

Guiding Principles

The CARE Act addresses the health needs of persons living with HIV disease (PLWH) by funding primary health care and support services that enhance access to and retention in care. The following principles were crafted by HAB to guide CARE Act programs in implementing CARE Act provisions and emerging challenges in HIV/AIDS care:

- **Revise care systems to meet emerging needs.** The CARE Act stresses the role of local planning and decision making, with broad community involvement, to determine how to best meet HIV/AIDS care needs. This requires assessing the shifting demographics of new HIV/AIDS cases and revising care systems (e.g., capacity development to expand available services) to meet the needs of emerging communities and populations. A priority focus is on meeting the needs of traditionally underserved populations hardest hit by the epidemic, particularly PLWH who know their HIV status and are not in care. This entails outreach, early intervention services (EIS), and other needed services to ensure that clients receive primary health care and supportive services, directly or through appropriate

linkages.

- **Ensure access to quality HIV/AIDS care.** The quality of HIV/AIDS medical care-including combination antiretroviral therapies and prophylaxis/treatment for opportunistic infections, can make a difference in the lives of PLWH. Programs should use quality management programs to ensure that available treatments are accessible and delivered according to established HIV-related treatment guidelines.
- **Coordinate CARE Act services with other health care delivery systems.** Programs need to use CARE Act services to fill gaps in care. This requires coordination across CARE Act programs and with other federal/state/local programs. Such coordination can help maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS-related services within managed care plans (particularly Medicaid managed care).
- **Evaluate the impact of CARE Act funds and make needed improvements.** Federal policy and funding decisions are increasingly determined by outcomes. Programs need to document the impact of CARE Act funds on improving access to quality care/treatment as well as areas of continued need. Programs also need to have in place quality assurance and evaluation mechanisms that assess the effects of CARE Act resources on the health outcomes of clients

SPECIAL INITIATIVES

Each year, OA applies for Title II funding from HRSA utilizing the Grant Application Guidance provided by HRSA. The Guidance provides assistance to OA in preparing the grant application as well as information on current and new program initiatives. The Grant Application Guidance for 2004/2005 contained the following special initiatives.

New Prevention Initiative

The Centers for Disease Control and Prevention (CDC) are refocusing some HIV prevention activities to reduce the number of new HIV infections in the U.S. More emphasis is being placed on the following: counseling,

testing and referral for an estimated 180,000 – 280,000 persons who are believed to be infected but unaware of their HIV status; partner notification; prevention services for people living with HIV (PLWH); and promoting routine and universal HIV testing as a part of prenatal care.

CDC's four strategies for accomplishing this include:

- Making HIV counseling and testing a routine part of medical care;
- Creating new models for diagnosing HIV infection, including rapid testing;
- Improving and expanding prevention services for persons living with HIV; and
- Decreasing perinatal HIV transmission.

The impact of this initiative will be reflected in the number of newly identified HIV-positive individuals who are made aware of their status and seek appropriate health care services. It is incumbent that all Title II grantees fully reassess their priorities and allocations for services and demonstrate that these new initiatives have been taken into consideration.

**Minority AIDS Initiative
(MAI)**

Since 1999, Congress has provided dedicated funds for the Minority AIDS Initiative (MAI) to expand or support new initiatives that are intended to reduce HIV-related health disparities and to improve HIV-related health outcomes for HIV-infected African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians, and Pacific Islanders. MAI funds are expected to expand or improve medical and support-service capacity in communities of color and to expand or improve culturally and linguistically appropriate peer-treatment education to individuals living with HIV. Please refer to the HAB website at www.hab.hrsa.gov for more information and updates on program policy notes.

INTENTION OF FUNDS

Subject to the availability of appropriations, HRSA makes grants to states to enable the states to improve the quality, availability, and organization of health care and support services for individuals and their families with HIV disease.

Title II funding is used to assist states and territories in developing and/or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families living with HIV. The Centers for Disease Control and Prevention's (CDC's) initiative, "Advancing HIV Prevention: New Strategies for a Changing Epidemic" may identify significant new numbers of people living with HIV/AIDS (PLWH) who will be seeking services. This will require a careful reassessment of how the state/territory will assure access to primary care and medications, support the state AIDS Drug Assistance Program (ADAP), and ensure provision of critical support services necessary to maintain individuals in the system of care. In light of the CDC initiative and efforts under way to describe unmet need, states should allocate funds for essential core services: 1) primary medical care consistent with Public Health Service (PHS) treatment guidelines; 2) HIV related medications; 3) mental health treatment; 4) substance abuse treatment; 5) oral health; and 6) case management.

The CARE Act emphasizes that such care and support be part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated.

**FEDERAL
REQUIREMENTS OF THE
CARE SERVICES
PROGRAM**

Payer of Last Resort

The Ryan White CARE Act stipulates that "funds received ... will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by sources other than Ryan White funds. At the individual client level, this means that grantees and/or their subcontractors are

expected to make reasonable efforts to secure other funding instead of CARE Act funds whenever possible. In support of this intent, it is an appropriate use of CARE Act funds to provide case management or other services which have as a central function ensuring that eligibility for other funding sources (e.g., Medi-Cal or Medicare, other local or state-funded HIV/AIDS programs, or private sector funding, etc.) is aggressively and consistently pursued.

**Third Party
Reimbursement**

Fiscal agents and service providers are encouraged to make effective use of strategies to coordinate between Title II and third-party payers that are ultimately responsible for paying the cost of services provided to eligible/covered clients. Third-party payer sources include Medi-Cal, State Children's Health Insurance Programs (SCHIP), Medicare and private insurance. Service providers who provide Medi-Cal reimbursable services must be Medi-Cal certified. CARE Act funded services may not be used to pay for services that are covered by a third party.

Client Eligibility

Individuals and their families with HIV disease are eligible for services. Proof of HIV diagnosis is required. The proof of HIV diagnosis must contain the client's name, i.e., a physician diagnosis or positive test result with the client's name on the diagnosis or test result. Anonymous testing results are not acceptable.

**Women, Infants,
Children, and Youth
(WICY)**

The CARE Act Amendment of 2000 states:

1. "For the purpose of providing health and support services to infants, children, youth and women with HIV disease, including treatment measures to prevent the perinatal transmission of HIV, a state shall for each of such populations use, of the funds allocated under this part to the state for a fiscal year, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in the state) with acquired immune deficiency syndrome to the general population in the state of individuals with such syndrome."

2. With respect to the population involved, the Secretary may provide to a state a waiver of the requirement of paragraph (1) if the state demonstrates to the satisfaction of the Secretary that the population is receiving HIV-related health services through the State Medicaid Program under title XIX of the Social Security Act, the State children's health insurance program under title XXI of such Act, or other federal or state programs"

The reauthorized Ryan White CARE Act of 2000 added the priority population of youth to the women, infants and children reporting requirement. Additionally, CARE Act language requires that each category be accounted for separately. In California, (including Eligible Metropolitan Areas that also receive funds from other CARE Act titles), the populations of youth, children and infants each account for less than one percent. Due to the other state and federal programs devoted to serving these populations, we usually request a waiver from the Health Resources Services Administration (HRSA) excusing the reporting of this information.

Until we receive waiver approval, however, you are required to track expenditures for each of the following categories:

Category	Age
Infants	Birth to 12 months
Children	1 to 12 years
Youth	13 – 24 yrs
Women	25 years and older

As a guideline, please note the following statewide percentages for these categories:

Category	Statewide Percentage
Infants	.01%
Children	.28%
Youth	.89%
Women	10.5%

Income Guidelines

Most providers do not charge for services. Providers who charge for services must comply with the following requirements regarding imposition of charges for services:

- A. In the case of individuals with an income less than or equal to 100 percent of the official poverty line, the provider will not impose charges on any such individual for the provision of services under the Care Services Program grant.
- B. In the case of individuals with an income greater than 100 percent of the official poverty line, the provider:
 - 1. Will impose charges on each such individual for the provision of such services; and
 - 2. Will impose charges according to a schedule of charges that is made available to the public.
- C. In the case of individuals with an income greater than 100 percent of the official poverty line and not exceeding 200 percent of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 5 percent of the annual gross income of the individual involved.
- D. In the case of individuals with an income greater than 200 percent of the official poverty line and not exceeding 300 percent of such poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 7 percent of the annual gross income of the individual involved.
- E. In the case of individuals with an income greater than 300 percent of the official poverty line, the provider will not, for any calendar year, impose charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

Service Categories

Social and support services funded by the CARE Act, along with a detailed description of each service, are listed in Exhibit 4. Only those services described in Exhibit 4 can be funded through the CARE Act.

Additional Guidance on
Allowable Uses of Funds
for Service Categories

The following policy memos (copies are included as Exhibit 5) have been issued by HRSA:

- Program Policy Notice (PPN) No. 97-01 and 97-02, first issued February 1, 1997, and revised June 1, 2000
- PPN 97-03 first issued March 31, 1997 and revised June 1, 2000

The following provides clarification regarding HRSA's guidance:

Funds may **not** be used:

- To purchase or improve (other than minor remodeling) any building or other facility
- For items or services that have already been paid for, or can reasonably be expected to be paid for by another source
- To pay for automobile parts, repairs, maintenance or any other costs associated with a vehicle such as lease or loan payments, insurance, or license and registration fees
- To make cash payments to people receiving services under this Act
- To pay for household appliances, pet care, pet foods or products
- To purchase tobacco, lotto tickets, clothing
- To pay for funeral, burial, cremation, or related expenses
- For syringe exchange programs
- To support employment, vocational rehabilitation, or employment-readiness services
- To pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied)
- To pay for off-premise social/recreational activities
- To purchase medical marijuana
- For complementary therapy – this category, which was under Other Services, was removed by HRSA

- To pay for complementary therapies such as massage and Chinese herbal therapy

Bulk Purchases

The OA Management Memo 00-03 outlines the policy regarding bulk purchase(s) of products or vouchers.

Housing Referrals

The OA Management Memo 99-08 summarizes and transmits the HIV/AIDS Bureau (HAB) Policy Notice 99-02. The HAB policy notice describes the conditions under which housing and related services may be funded. In addition, HRSA publication, "Housing is Health Care: A Guide to Implementing the HIV/AIDS Bureau (HAB) Ryan White CARE Act Housing Policy," is available on HRSA's webpage, www.hab.hrsa.gov ID# HAB00215.

Diagnostics and Laboratory Tests

The OA Management Memo 00-01 summarizes and transmits the HAB Policy Notice 99-03. The HAB policy notice describes the use of Ryan White CARE Act funds for HIV diagnostics and laboratory tests. Diagnostics and laboratory tests are included under the service category Ambulatory/Outpatient Medical Care.

Emergency Financial Assistance

In order to utilize this category that provides short-term payments for essential utilities or medication assistance, guidelines for expenditures must be established by the Fiscal Agent and carefully monitored to ensure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

Payments for Medication

Medi-Cal Medication Coverage

Technically, Medi-Cal covers all FDA approved drugs. Medi-Cal does require that the medications be prescribed for use in their FDA approved form. Medi-Cal has the authority to create a formulary in an effort to manage cost.

Medi-Cal Approval Process Treatment Authorization Request (TARs) –

Medication related TARs are to be processed within 24 hours of receipt. In emergency situations, pharmacists may provide 72 hours worth of drugs pending TAR approval. If Medi-Cal requires

additional information to process the TAR, the 24-hour timeline starts over once the information is submitted. Any TAR denial should be in writing and should include appeal instructions.

The Medi-Cal system can be very frustrating and the authorization process can create a lot of work, so the tendency is to want to bill the programs that are easier to access. HRSA is very clear about this practice: "Grantees and their contractors are expected to seek payment from Medicaid (Medi-Cal) when they provide a Medicaid covered service for Medicaid beneficiaries and also back bill Medicaid for CARE Act funded services provided for all Medicaid eligible clients upon determination."

**Partner Counseling and
Referral Services (PCRS)**

The Ryan White CARE Act states, "The State requires that the public health officer of the State carry out a program of partner notification to inform partners of individuals with HIV disease that the partners may have been exposed to the disease." The California Partner Counseling and Referral Services (PCRS) program operates within the Disease Intervention Section of the California STD Control Branch under the guidance of the State Office of AIDS. Through a capacity building approach, the PCRS program provides training and technical assistance to all 61 health jurisdictions throughout California. Technical support is provided by regionally based PCRS managers and coordinators who work directly with local HIV prevention and care/treatment programs. By supporting the development, implementation and expansion of PCRS activities at the local level, the PCRS program helps to facilitate the delivery of quality HIV partner notification services to all persons living with HIV in California. Please see Exhibit 14 for a listing of the PCRS coordinator for your area.

In California, PCRS is known as the California Disclosure Assistance Program (CDAP).

The State of California, Department of Health Services (DHS), Office of AIDS (OA) implements and oversees the Care Services Program (CSP) in California under the guidance of HRSA. Please see Exhibit 15 for the DHS and OA organizational charts.

**CARE SERVICES
PROGRAM (CSP)
STAFFING**

The OA contracts with county health departments and community-based organizations (CBOs) to implement the CSP in California. The fiscal staff contacts at each county or CBO is called the Fiscal Agent (FA). Each CSP is assigned an OA staff contact person, or Care Services Advisor. The Care Services Advisor provides technical assistance and contract oversight. Please see Exhibit 2 for a complete listing of Fiscal Agents and Exhibit 3 for a listing of Care Services Advisors.

SERVICE MODELS

Two service delivery models utilized in California are the Consortia Program, utilized in the Eligible Metropolitan Areas (EMAs), and Direct Services Program, utilized in the non-EMA areas. Though these two models are separate funding categories eligible under the CARE Act, the OA refers to both as the CSP. In both models of service delivery, the flow of funding is the same.

In 2000 and 2001, counties experienced a disbanding of their HIV Care Consortia and, through a pilot program, continued to receive Title II funding through the Direct Services category.

In 2002, in response to the ongoing input and comments from HIV Care Consortia members statewide, and the knowledge that HIV Care Consortia would be called upon to develop more detailed local HIV service delivery plans, OA carried out the evaluation of California's HIV Care Consortia model. Additionally, OA convened focus groups of consumers, service providers, and Fiscal Agents who have been current or past participants on HIV Care Consortia and challenged them to accomplish the following:

- Evaluate the current consortia model as a tool for local planning activities
- Suggest other models for local planning efforts that

would:

- ✓ Meet the unique needs of each community.
- ✓ Provide an open and safe forum for community input and community participation.
- ✓ Include HRSA expanded consultative requirements.
- ✓ Address the need for collaborative planning efforts.
- ✓ Address the upcoming changes to HIV service delivery due to efforts pertaining to prevention with positives, rapid testing, and HIV reporting.
- ✓ Support the development of local HIV service delivery plans that address the needs to ensure access to healthcare and reducing health disparities.
- ✓ Not hinder the participation of prevention's Local Implementation Groups.

The focus groups reported that the HIV Care Consortia model was a barrier to adequate local HIV service delivery planning. The following were identified as issues that pertain to the HIV Care Consortia model:

- Membership requirements are often difficult to meet due to several factors including: confidentiality for consumers, availability and interest of volunteers, and FA and service agency workload.
- Low membership resulting in overloaded volunteers who burn out and resign.
- Intensive administrative workload for the FA takes away from the time the FA could spend in pursuing linkages to other agencies and programs.
- Community input is not adequate due to various issues, including: the need for transportation and childcare to attend monthly meetings, scheduling conflicts, discomfort or fear in making comments about service delivery when the service agency is in attendance as a voting member, feeling of not being heard or valued as a member of a local HIV Care Consortium.
- Over the past years the roles and responsibilities of FAs, service agencies, and community members have shifted. Current roles, responsibilities, and authorities are unclear.

- Administrative burden for HIV Care Consortia members creates burnout.

The focus group designed a variety of unique models for service delivery planning. This experience highlighted that counties/regions needed to individualize their planning model based on all the various factors inherent in their jurisdiction: services currently available, availability of funding and other resources, the populations being served, political issues, other organizations providing services, other CARE Act titles providing services in the region, etc.

The focus groups suggested that OA:

- Allow more Consortia to join the Direct Services Pilot Project.
- Create a community input and participation process that addresses the specific needs of the community.
- Redefine membership requirements.
- Create planning bodies and advisory groups as needed rather than having mandatory, ongoing, monthly meetings.
- Increase communication from OA.
- Develop a model that will facilitate participation by other agencies and organizations.

Based upon the evaluation of the Direct Services Pilot Project, comments received through the evaluation of California's HIV Care Consortia Model, recommendations provided by the focus groups, and the legislative parameters of the reauthorized CARE Act, OA developed a revised structure for local HIV/AIDS planning and administration of HIV service delivery. To achieve this, the delivery of HIV service dollars **in non-EMA** areas, was shifted from the HIV Care Consortia category to the Direct Services category.

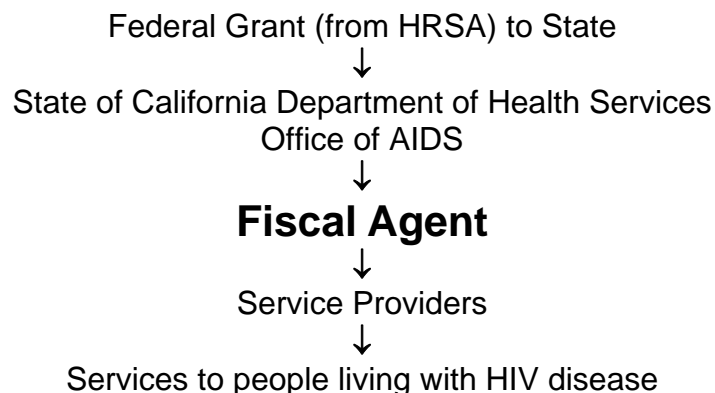
**Consortia Program (EMA
areas only)**

In this model, the consortium (planning council) conducts or updates an assessment of HIV/AIDS service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates the consortium's (planning council's) success in responding to service needs, and evaluates the cost-effectiveness of the mechanisms used to deliver comprehensive care.

Direct Services Program

In this model, the FA convenes an advisory group, which includes infected and affected community members, who will meet no less than once per program year. The advisory group provides input into the needs assessment and comprehensive planning processes. Please refer to Chapter 4 for FA roles and responsibilities.

**FLOW OF FUNDING FOR
THE CARE SERVICES
PROGRAM IN
CALIFORNIA**



APPLICATION PROCESS

**Federal Application
Process:**

Annually, OA prepares and submits a grant application to HRSA. The grant application is similar to the application submitted by FAs to OA, i.e., it includes budget detail, goals and objectives narrative, and addresses specific questions posed by HRSA. OA depends on the information provided by FAs and service providers in the mid-year and year-end reports, service delivery plans, management memo responses, and invoices to develop the application package. It is imperative that the information submitted to OA is timely and accurate.

**State Application
Process:**

OA annually prepares and transmits an application package to all FAs. The package includes: guidelines on how to complete the application, forms to be utilized, and a list of services that may be funded for technical assistance, a list of Care Services Advisors and their assigned areas.

It is vital that the application be completed and returned to OA by the due date. Timely submission ensures time for each advisor to review and approve the applications and submit them to OA Contract and Reimbursement Unit to ensure that contracts are prepared and executed before the new contract year begins on April 1.

TIERED APPROACH

HIV service needs and resources vary significantly in a state as geographically, culturally and economically diverse as California. Service needs of existing and emerging populations, cultural issues, administrative capacity, technical assistance needs, and available funding differs greatly throughout the state. It is imperative that the Care Services Program address these changing needs by maintaining the flexibility needed to address service needs in these varying local environments.

OA developed a tiered approach to begin addressing two areas of concern identified by various Fiscal Agents and advisory groups—increased administrative responsibilities and imbalanced funding levels. These issues have been addressed through the development of three categories, or tiers, of counties where funding levels, as well as administrative responsibilities, have been established at a level commensurate with local needs and utilization.

Tier A Counties:

Alpine
Colusa
Modoc
Mono
Sierra

- Tier A counties are identified as counties with six or fewer Persons Living With AIDS (PLWA) or persons served.
- In Year 11, Tier A counties received an allocation based upon the higher of the following:
 - ✓ Statewide HIV funding average per capita (\$4,175)
 - ✓ Formula allocation (not subject to 95 percent hold harmless)
 - ✓ Established Year 11 floor of \$30,000
- Tier A counties received a Year 12 allocation based

upon the higher of the following:

- ✓ Statewide HIV funding average per capita (to be determined)
- ✓ Formula allocation (not subject to 95 percent hold harmless)
- ✓ Established Year 12 floor of \$15,000

Of particular importance to creation of this model was the need to determine the number of persons accessing services in each county. AIDS Drug Assistance Program (ADAP) and Medi-Cal data, which provided the number of persons per county accessing those two programs for HIV medications, were considered to be the most reliable indicators currently available for determining the number of eligible persons accessing HIV services in each county.

Tier B Counties:

Fresno
Kern
Stanislaus
San Luis Obispo
San Joaquin

- Tier B counties are those counties significantly affected by increased demand for services, as demonstrated through caseload data, increasing persons accessing services, increasing PLWA, decreasing Title II Care Services Program funding, and per capita HIV/AIDS funding that falls below the statewide average.
- Tier B counties receive an allocation based upon the formula. In addition, Tier B counties received a *pro rata* augmentation of CSP funds in Program Years 11 and 12.

Tier C:

- Tier C counties are those EMA and non-EMA counties that do not fall into Tiers A or B, and were not subjected to funding or significant administrative revisions in Year 11.
- Tier C counties will receive an allocation based upon the formula.

Resource Allocation

Funding for the CSP was allocated to counties on a formula basis, which is based primarily upon the total PLWA in each county. The allocations were subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The statewide California HIV Planning Group (CHPG) makes recommendations to OA regarding the process for allocating CSP funds. The CHPG determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. The allocation process has created funding imbalances and has not kept pace with the needs of counties experiencing dramatic increases in service needs. The CHPG recommended that, due to these imbalances and HRSA's emphasis on access to HIV services, the allocation process should be revised.

**Revised Approach to
Resource Allocation**

OA accepted CHPG's recommendation to develop a tiered approach to the allocation of CSP resources. This revision was phased in throughout program years 11 and 12. Of particular importance to creating this model was the need to determine the number of persons accessing services in each county. ADAP and Medi-Cal data, which provided the number of persons per county accessing those two programs for HIV medications, were considered to be the most reliable indicators currently available for determining the number of eligible persons accessing HIV services in each county. Please see Management Memo 01-01 detailing the Tiered Approach.

The Resource Allocation Committee of the California HIV Planning Group reviewed extensive data sets to revise the current formula with the best information available at this time. The factors in the current formula were revised to reflect cumulative AIDS cases, population scarcity to benefit rural communities, and a factor related to utilization and migration was added to reflect where clients receive services. The Committee also recommended maintaining a hold harmless clause at 95% of previous years funding and a floor of \$15,000.

Anticipating that HIV Surveillance data and ARIES data will be available by 2006, the Committee also recommended that this data be used in the formula for AIDS data and utilization.

STANDARD AGREEMENT The standard agreement is the FA contract with OA . See Exhibit 13.

Amendments Should either party during the life of the contract desire to change the contract, such changes shall be proposed in writing to the other party who will, within 30 calendar days of the receipt of the request, accept or reject the proposed changes in writing. Once accepted, the contract shall be amended to provide the change mutually agreed upon.

Line Item Shifts Subject to the prior review and approval of the State, line item shifts of up to 15% of the annual contract total are allowed, so long as the annual agreement total neither increases nor decreases.

Fiscal Agents must submit an In-House Revision form, for approval, for line item shifts to OA. Please contact your Care Services Advisor for a copy of the In-House Revision form.

Budget Revisions Revisions of dollar amounts or service categories among subcontractors are referred to as budget revisions. Because these dollar amounts are reported in the "Other Costs" line item, they are not considered line-item changes. Subcontractors must notify the Fiscal Agent of any budget shifts or changes in services or allocations. The Fiscal Agent must notify their Care Services Advisor, via e-mail, before the changes go into effect. The e-mail must include where funds/services are reduced and where the funds/services are increased.

Encumbrances The state fiscal year is July 1 through June 30. The CSP year, April 1 through March 31, overlaps the state fiscal year. Funds are encumbered for forty percent of the maximum allowable amount under the contract for the CSP through June 30. Sixty percent of the maximum amount allowed under the contract is encumbered for

July 1 through March 31. Any funds not expended during April 1 – June 30 are disencumbered and moved to help cover expenditures for the remaining year. When expenses are incurred April 1 – June 30 and are not invoiced in those months, a supplemental invoice may be submitted. The CSP Advisor must be notified by **November 1** of the contract year if a supplemental invoice will be submitted.

INVOICING PROCESS

The FA is responsible for implementing and monitoring a system to administer Title II funds using standard accounting practices. The CSP is a reimbursement program therefore services are provided before an invoice is submitted to the FA.

Service Providers

- Provide service, send invoice to FA. (Due date is determined by the FA.)
- Provide back-up documentation with the invoice unless the FA conducts quarterly monitoring visits.
- Keep invoice documentation for a minimum of 3 years following the date of final payment authorization.
- If documentation identifies client, it must be kept in a locked, secure area to ensure client confidentiality.
- Final invoice due date is determined by the FA.

Fiscal Agent

- Pay service providers, submit monthly or quarterly invoice to OA.
- Invoices are due 45 days following the end of a billing period. For example:
 - Monthly invoices: An invoice for April services is due June 15.
 - Quarterly invoices: An invoice for services provided in the first quarter is due August 15.
- Invoices must be on the agency's letterhead in the approved format (see Exhibit 6).
- Invoices must include an invoice detail form (see Exhibit 7). The services and allocation amounts must match the budget detail that was submitted with the application. Any changes that are made with the budget by the FA or service provider must be submitted to the CSP Adviser or CSP FA in advance. Updated invoice detail forms may be e-mailed to you on request.
- Final invoices are due 90 days following the expiration date of the contract year.

Prompt Payment Act

As of January 1, 1999, all state agencies were required to comply with the provisions of the California Prompt Payment Act. This act requires that state agencies pay undisputed invoices within 45 calendar days (30 days for small businesses; County Health Departments are exempt). It also requires state agencies to automatically calculate and pay late payment penalties if undisputed invoices are not processed and paid by the date required. Late payment penalties will be paid from the state agency's support funds.

To comply with the requirements of this act, the OA fiscal analyst must approve or deny invoices within three working days. Due to this timeframe, the OA fiscal analyst may not have the opportunity to contact agencies to correct invoice errors. Any incorrect invoices will be returned to the FA and payment will be delayed until a correct invoice is received and processed.

Some common invoice errors are:

- No signature
- Mathematical errors
- Advances not included
- Line items overspent
- Invoice format does not correspond with contract

**Monthly vs. Quarterly
Invoicing**

FAs have the option to invoice quarterly or monthly. This decision is made at the beginning of the contract year and communicated to the CSP Advisor.

**Advances and
Repayment of Advances**

Private nonprofit agencies may request advance payments up to 25 percent of their total CSP budget. Agencies receiving \$200,000 or less may request one or two advances; agencies receiving over \$200,000 may request only one advance. The CSP contract year (April 1 – March 31) crosses over the state fiscal year (July 1 – June 30). The table below explains the advance process.

If you request	Then
One Advance	Processing will be delayed until passage of the annual State Budget Act.
Two Advances	<p>You will receive:</p> <ul style="list-style-type: none"> • One advance for up to 8 percent, and • One advance for up to 17 percent <p>Caution: The second advance will not be processed until passage of the annual State Budget Act.</p>

The FA may ask for an advance by submitting a written request on agency letterhead to the CSP Advisor. The request should include:

- Contract number
- County name(s)
- Number of advances:
 - ✓ One advance for a maximum of 25 percent, liquidated beginning the month after the State Budget Act passes and completed by March 31.
 - ✓ Two advances – one for up to 8 percent, liquidated with the May and June invoices; and one for up to 17 percent, liquidated with the September through March invoices
- Bank account number*
- Name and address of bank

*All advances must be placed in an interest-bearing account.

**EXPENDITURE
MONITORING**

To ensure that all CARE Act funds are expended by March 31, current and prior year financial status reports are reviewed by the CSP Advisor and FA to identify those agencies with demonstrated low expenditure rates. The CSP Advisor will contact FAs of agencies with low expenditure rates to determine what their plan is to ensure 100 percent expenditure. FAs are expected to monitor expenditures and work with service providers to ensure 100 percent expenditure.

PROGRAM MONITORING

By OA

In accordance with CARE Act requirements, OA CSP Advisors monitor CARE Act contracts. The goal of contract monitoring is to ensure compliance with state and Federal contract requirements. OA's focus is to provide technical assistance to FAs and service providers to ensure continued compliance. Contract monitoring is undertaken as needed or every three years and includes both program and fiscal monitoring activities.

Program monitoring means assessing the quality and quantity of the services being provided by a particular contractor. Program monitoring may include reviewing program reports, conducting site visits, and reviewing client records or charts.

Fiscal monitoring means assessing how quickly and efficiently a contractor uses the CARE Act funding it receives and whether funds are used for approved purposes. Fiscal monitoring includes regular review and assessment of contractor expenditure patterns and processes to ensure adherence to federal, state, and local rules and guidelines on the use of CARE Act funds.

HAB expects grantees to be accountable for the expenditure of funds awarded under Title II. As described in an April 15, 2004, letter from HAB Associate Administrator Dr. Parham, the Office of Management and Budget (OMB) Program Assessment Rating Tool (PART) for HRSA, as well as the Office of the Inspector General (OIG) report on DSS grantee monitoring of

subgrantees/contractors, have both been highly critical of the stewardship of Title II funds by grantees. Thus, a higher priority is being given to grantees' demonstrated monitoring of subgrantee performance, including acceptable accounting procedures. HAB also wants to ensure that Title II funds are the payer of last resort. In addition, HRSA now requires that all grantees have on file for inspection the following documents:

- a) A copy of the procurement document for each funded entity (Contract);
- b) The most recent fiscal report;
- c) The most recent program report; and
- d) A site visit report.

By the Fiscal Agent

Annual onsite monitoring of all service providers by the FA is required. Annual onsite monitoring provides each FA the opportunity to ensure contract compliance, effective and efficient use of program funds, and adherence to corrective action plans. OA utilizes monitoring tools during monitoring visits to FAs and their service providers. The tools are revised annually to reflect current FA contract requirements. FAs may choose to use the service provider monitoring tool during their annual visits. If you would like a copy of this tool, please contact your CSP Advisor.

REPORTING REQUIREMENTS

OA, as grantee for the CSP funding, must comply with HRSA reporting requirements. FAs are, therefore, required to submit reports in a timely manner to OA. Failure to submit these reports by the due date may result in a 10 percent reduction of administrative monies. The required reports are:

Report	Due Date(s)
Mid-Year and Year-End Reports	11/15 - Mid-Year 6/15 - Year-End
Care Act Data Report (CADR)	2/15 - 12-month report (Jan to Dec)

**Mid-Year and Year-End
Reports**

The three components of the mid-year and year-end reports are:

1. The Financial Status Report (Exhibit 8) contains the following:
 - Contractor's and subcontractor's administrative costs
 - The amount of funds obligated to each subcontractor
 - The total expended to date by each subcontractor
 - Balance
 - Percentage expended
 - Total clients served (unduplicated)
2. The Narrative Report contains the following:
 - Progress made in achieving the administrative and service delivery goals and objectives outlined in the application for Title II funds
 - Description of any general accomplishments
 - Identification of any technical assistance needs
3. The Women, Infants, Children and Youths (WICY) financial status reporting form contains the following funds allocated, expended and the balance for each of the four categories listed below:
 - Women (females aged 25 and older)
 - Infants (birth through 12 months)
 - Children (ages 1 through 12)
 - Youth (13 to 24 years of age)

**CARE Act Data Report
(CADR)**

The CARE Act Data Report (CADR), which replaces the Annual Administrative Report, is a combination of reporting forms from all of the CARE titles. It is designed to collect unduplicated aggregate level data for better planning and funding allocation for all CARE Act programs.

The goal of the CADR is to reduce the reporting burden for grantees and service providers with concurrent reporting responsibilities, and to eliminate title-specific reporting in order to reduce duplications among grantees and providers funded through multiple CARE Act titles.

The CADR consists of client and service data collected by the FA throughout the year.

The CARE Act fiscal year is April 1 through March 31. The CADR report, due February 15, is a twelve-month report which consists of data collected from the previous contract year, January through March, and the current contract year, April 1 through December 30. Please see Exhibit 10 for a sample of the CADR forms and instructions for completion. If you would like a copy of the CARE Act Data Report (CADR) Guidance Manual please contact Denise Absher, OA, at (916) 449-5845.

Data Elements

The data elements included in the CADR are listed below. FAs, through the contract with OA, agree to comply with future data requirements developed by federal program staff and the state.

A. Provider Agency Contact Information

1. Provider Name
2. Provider Address
3. Provider Contact Information (Name, Title, Phone Number, Fax Number, E-Mail Address, and Taxpayer ID)

B. Reporting and Program Information

1. Reporting Period
2. Reporting Scope
3. Grantee ID # (0600-All California Title II providers have the same grantee number)
4. Provider Type
5. Section 330 Funding (Yes/No)
6. Ownership Status
7. Source of Ryan White CARE Act Funding
8. Services Provided to the Grantee
9. ADAP Program (Yes/No)
10. Type of ADAP Program
11. Health Insurance Program (Yes/No)
12. Target Populations
13. Agency Category Description

14. Total Paid FTEs
15. Total Volunteer FTEs
16. Amount of Title I, Title II, Title III, and Title IV Funding
17. Amount Expended on Oral Health Care

C. Client Information

1. Total Number of Unduplicated Clients
2. Total Number of New Clients Served
3. Gender Distribution of Clients
4. Age Distribution of Clients
5. Hispanic or Latino/a Ethnicity
6. Racial Distribution of Clients
7. Household Income
8. Housing/Living Arrangements
9. Medical Insurance
10. HIV/AIDS Status
11. Vital/Enrollment Status

D. Service Information

1. Total Number of Clients (HIV+ and Affected) Receiving Services AND Total Number of Visits for the Following Services:
 - a) Ambulatory/Outpatient Medical Care
 - b) Mental Health Services
 - c) Oral Health Care
 - d) Substance Abuse Services-Outpatient
 - e) Substance Abuse Services-Residential
 - f) Rehabilitation Services
 - g) Home Health Para-Professional Care
 - h) Home Health Professional Care
 - i) Home Health Specialized Care
 - j) Case Management Services
2. Total Number of Clients (HIV+ and Affected) Receiving the Following Services:
 - a) Buddy/Companion Service
 - b) Child Care Services
 - c) Child Welfare Services

- d) Client Advocacy
- e) Day/Respite Care for Adults
- f) Developmental Assessment/Early Intervention Services
- g) Early Intervention Services for Titles I and II
- h) Emergency Financial Assistance
- i) Food Bank/Home Delivered Meals
- j) Health Education/Risk Reduction
- k) Housing Services
- l) Legal Services
- m) Nutritional Counseling
- n) Outreach Services
- o) Permanency Planning
- p) Psychosocial Support
- q) Referral for Health Care/Support Services
- r) Referrals to Clinical Research
- s) Residential or In-Home Hospice
- t) Transportation Services
- u) Treatment Adherence Counseling
- v) Other Services

E. HIV Counseling and Testing

- 1. Counseling and Testing Provided (Yes/No)
- 2. Number of Infants Tested
- 3. Ryan White CARE Act Funds Used (Yes/No)
- 4. Number of Individuals Receiving HIV Pretest Counseling
 - a. Confidential
 - b. Anonymous
- 5. Of the Individuals Receiving Pretest Counseling, Number Tested for HIV
 - a. Confidential
 - b. Anonymous
- 6. Of the Individuals Receiving Pretest Counseling and Tested for HIV, Number with Positive Test Result
- 7. Of the Individuals Receiving Pretest Counseling and Tested for HIV, Number Receiving Post-test Counseling
 - a. Confidential

- b. Anonymous
 - 8. Of the Individuals Tested Positive, Number Not Returning for Post-test Counseling
 - 9. Program Offered Partner Notification Services (Yes/No)
 - 10. Number of At-Risk Partners Notified
- F. Medical Information (Report Only on Clients Receiving Medical Care)
- 1. Number of Unduplicated Clients Receiving Medical Care by Gender
 - 2. Number of HIV Positive Clients by Risk Factor
 - 3. Number of Clients Receiving the Following:
 - a. TB Skin Test
 - b. TB Treatment
 - c. Screening/Testing for Syphilis
 - d. Treatment for Syphilis
 - e. Screening/Testing for STI(s)
 - f. Treatment for STI (s)
 - g. Screening/Testing for Hepatitis C
 - h. Treatment for Hepatitis C
 - 4. Number of Clients Diagnosed with Specific AIDS-Defining Conditions
 - a. PCP
 - b. MAC
 - c. MAC TB
 - d. Cytomegalovirus Disease
 - e. Toxoplasmosis
 - f. Cervical Cancer
 - g. Other AIDS-Defining Condition
 - 5. Number of Clients on Antiretroviral Therapies
 - a. None
 - b. HAART
 - c. Salvage
 - d. Other (Mono or Dual Therapy)
 - e. Unknown/Unreported
 - f. Total
 - 6. Number of Clients Receiving a Pelvic Exam and Pap Smear
 - 7. Number of HIV Positive Pregnant Clients
 - 8. Of the Number of HIV Positive Pregnant Clients, Number Entering Care in:

- a. First Trimester
 - b. Second Trimester
 - c. Third Trimester
 - d. At Time of Delivery
 - e. Total
9. Number of Pregnant Clients Receiving Antiretroviral Medications to Prevent Transmission
10. Number of Children Delivered to HIV Positive Clients
11. Of the Number of Children Delivered, Number HIV Positive

Client Level Data Reporting

Effective April 1, 2003, providers were required to collect client-level data. The data must be reported to OA on a quarterly basis. Client-level data reporting overcomes the limitations of the CADR that collects aggregate level data. Client-level data helps OA monitor health outcomes and service utilization patterns, and ensures the accuracy and usefulness of CSP data.

FAs may choose from one of the following software options to submit their data:

- The Ryan White CAREWare (The CAREWare technical support contact number is 1-877-294-3571. The software is free and available at www.hrsa.gov.)
- The CMP/CSP Database (free software). Please contact Denise Absher at (916) 449-5845, if you are using this software, or
- Provider's current data collection system provided it meets HRSA's export format specifications for submitting client-level data. (If providers prefer to use their current in-house system, please contact Denise Absher at the above number for the detailed export format.

The report submission consists of exporting data from your database and copying it onto a diskette. Client name and other identifying information must not be reported to OA. There are no forms to fill out for this submission; however, providers will still need to complete the CADR,

due annually on February 15. Data should be exported for the specific reporting periods noted below. The CAREWare software contains an export function that will easily accommodate this requirement.

Due dates for the data submissions are as follows:

- The First Quarter Report (April 1 through June 30) is due on July 31.
- The Second Quarter Report (July 1 through September 30) is due on October 31.
- The Third Quarter Report (October 1 through December 31) is due on January 31.
- The Fourth Quarter Report (January 1 through March 31) is due on April 30.

Please do not submit data via e-mail as OA has restrictions on the size of attachments that we are permitted to receive.

QUALITY MANAGEMENT (QM)

Quality Management programs are designed to bring equal access to quality care and services to all HIV-infected populations.

Quality Management should:

- Support the development of higher quality of care to people living with HIV disease (PLWH)
- Identify priority needs and client populations
- Support effective program management
- Demonstrate program value quantitatively by linking outputs (amounts of services provided) to outcomes (results)
- Identify and justify critical program activities and resources required to meet needs
- Enable local HIV service delivery networks and providers to perform better and to function as a system.

HRSA monitors OA compliance with quality management requirements through questions in the application

guidance, progress reports, and site visits. OA signs assurances in their annual applications attesting that appropriate quality management programs are in place.

Fiscal Agents must ensure that subcontractors have quality management (QM) programs in place. Through QM efforts, service providers should be able to identify problems in service delivery that may affect health status outcomes at the client and system-levels. Evidence of QM activities should be included in contract language with service providers, site-visit protocols, monitoring tools, and processes used by the Fiscal Agent. Further guidance and QM references are available at www.hab.hrsa.gov/tools/qm.

The Fiscal Agent's (FA) role is imperative to the success of the Title II CARE Act Program in California. The Fiscal Agent, via contract with the State of California Office of AIDS (OA), performs multiple financial and oversight tasks to ensure the efficiency and effectiveness of program expenditures.

**OVERVIEW OF FISCAL
AGENT RESPONSIBILITIES**

The Fiscal Agent is responsible for meeting all contractual and programmatic requirements for the Care Services Program (CSP) including:

- Developing a service delivery plan that offers comprehensive, ongoing health and support services to individuals with HIV/AIDS; that actively seeks individuals who know their HIV status but are not accessing services; and that reaches out to people who are HIV positive, but unaware of their HIV status. Activities necessary to complete a service delivery plan include needs assessment, priority setting and resource allocation, description of service delivery and effectiveness measures.
- Coordinating an advisory group that meets at least annually, made up of representatives from state, Federal and local programs and from communities that are reflective of HIV/AIDS infected and affected populations in the Fiscal Agent's jurisdiction (see Exhibit 16). This advisory group should provide input on issues such as needs assessment, service delivery plans, and comprehensive planning.
- Developing and maintaining working relationships with entities that provide key points of entry into medical care. The Fiscal Agent shall keep documentation of these working relationships. (See Exhibit 17)
- Ensuring that case management services that link available community support services to appropriate specialized medical services shall be provided for individuals residing in rural areas.
- Demonstrating availability of primary medical care of each population group with HIV disease outside of Title I areas.
- Ensuring services will be provided in a setting that is accessible to low-income individuals with HIV

disease.

- Providing outreach coordinated with all state and federal programs to low income individuals with HIV disease and to inform such individuals of the services available under Title II.
- Ensuring the provision of comprehensive outpatient health and support services based on the service delivery plan.
- To the maximum extent practical, ensuring that HIV-related health care and support services are delivered pursuant to a program established with assistance provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease.
- Ensuring that no less than the assigned amount of funding for women, infants, children and youth with HIV disease is spent.
- For the purpose of providing support services to women, infants, children and youth with HIV disease (including treatment measures to prevent the perinatal transmission of HIV), the Fiscal Agent shall use not less than the percentage constituted by the ratio of the population in such area of individuals with such syndrome.
- Ensuring that services provided are in accordance with HRSA's Program Policy Notice Number 97-02. (See Exhibit 5.)
- Ensuring that Care Services Program monies do not comprise more than sixty percent (60%) of any subcontractor's budget.
- Ensure that clients are eligible for services in accordance with HRSA's Program Policy Notice 97-01. (See Exhibit 5.)
- Ensuring that no more than ten percent (10%) of the allocation is used for non-direct service functions. (See Chapter 5, page 3 of this manual.)
- Ensuring that with prior written approval from the State, no more than five percent (5%) of the allocation is utilized to plan, conduct and evaluate the needs assessment process.
- Ensuring that FA notifies OA of changes in funding

among subcontractors.

- Ensuring that subcontractors who provide Medi-Cal reimbursable services are Medi-Cal certified.
- Ensuring that all approved subcontractor invoices are paid within 45 days of receipt.
- Conducting or updating an annual assessment of HIV/AIDS service needs for the geographic service area.
- Ensuring that no funds are used to purchase or improve (other than minor remodeling) any building or other facility.
- Ensuring that no funds are used to make cash payment to intended recipients of services.
- Ensuring that funds are payer of last resort.
- Ensuring that no funds are used to pay for automobile parts, repairs or maintenance; pet care or supplies; and funeral expenses.
- Ensuring that no funds are carried over into subsequent contract years.
- Ensuring that the requirements and guidelines in OA's application, management memos, and any subsequent additions or amendments are adhered to by FA.
- Administering funds; maintaining records and invoices using standard accounting practices; coordinating federal and state data reporting; and arranging for fiscal audits.
- Annually evaluating the cost-effectiveness of the mechanisms used to deliver comprehensive care.
- Ensuring the provision of comprehensive outpatient health and support services by establishing or revising and then implementing a service delivery plan based upon prioritized services.
- Complying with program guidelines issued by the Federal Government and OA.
- Ensuring that Management Memo responses are accurate, complete and received on or before the required response date.
- Ensuring compliance with contractual requirements regarding imposition of charges for services.
- No less than annually conducting site visits and

documenting/monitoring the activities of subcontractors to ensure contractual compliance.

- Providing any necessary assistance to the state in carrying out its monitoring activities and inspection rights as provided in this agreement.
- Making available all records, materials, data information, and appropriate staff to authorized State and/or federal representatives.
- Developing, implementing, and submitting a corrective plan to the state for approval for all deficiencies cited in the monitoring report.
- Ensuring that clients are informed of the availability of Partner Counseling and Referral Services (PCRS).
- Making staff available to OA for trainings and meetings.
- Attending and keeping written documentation of all advisory or focus group meetings.
- Providing advisory and focus groups with data.
- Not releasing any proposed publicity without the advance written permission of OA. OA, at its sole discretion, may approve or reject any proposed publicity, or may require specified modifications to proposed publicity.
- Agreeing to acknowledge state support by including a statement that the project was supported by funds received from the state on all reports or materials produced pursuant to the contract and on all published works or materials utilizing data resulting from the contract. This statement shall be included on the report cover or title page, or on the first page of any journal article.

**REQUIREMENTS TO
PERFORM THE ROLE OF
FISCAL AGENT**

A Fiscal Agent must be a local government agency, i.e., health department, or a private nonprofit organization. Private nonprofit organizations must have:

- Demonstrated experience with generally accepted accounting principals.
- Sufficient cash flow to assure no disruption in services in the event of invoicing reimbursement delays.
- Legal entity status.
- Program management experience.

**FISCAL AGENT'S ROLE IN
THE STATE APPLICATION
PROCESS**

OA annually prepares and transmits an application package to all Fiscal Agents. The package includes: guidelines on how to complete the application, forms to be utilized, a list of services that may be funded, OA goals for the upcoming year, and a list of Care Services Advisors and their assigned areas to contact for technical assistance.

It is the Fiscal Agent's responsibility to ensure the application is completed accurately and submitted to OA by the due date. Timely submission ensures time for each Care Services Advisor to review and approve the applications and submit them to OA Contracts Unit to ensuring that contracts are prepared and executed before the new contract year begins April 1.

**REQUEST FOR
APPLICATION (RFA)
PROCESS**

Once the service categories and percentages (or if known, the dollar amounts) allocated to those services are determined, the Fiscal Agent secures contractors to provide the services. The Fiscal Agent, whether a county agency, local health jurisdiction, or community-based organization, has sole responsibility for all phases of the contracting process including:

- Advertising
- Receiving bids
- Creating a bid evaluation process
- Awarding bids
- Creating an appeal process
- Resolving appeals, Any other activity involved with the contracting process

Appeal Process

The appeal process used by the Fiscal Agent should be the same as for any other contract managed by the Fiscal Agent. For example, contracts awarded by a county would be appealed through the county's established process. This process may involve many review levels, and may result in a final decision by the county board of supervisors. Likewise, contracts awarded by a community-based organization usually have an executive board that hears and makes decisions regarding contract appeals.

Awards to Service Providers

Private for-profit service providers may be used only when there are no nonprofit organizations able and willing to provide quality HIV services and the Fiscal Agent is able to document this fact.

An entity should only be deemed incapable of providing quality HIV care if written documentation of substantive quality of care deficiencies exists.

Cost of service may not be the sole determinant in the vendor selection processes, whether internal or external. Grantees must prohibit nonprofit contractors from serving as conduits who pass on their awards to for-profit corporations. FA may find it necessary to monitor membership of corporate boards in enforcing this prohibition. Proof of nonprofit status is required of all applicants claiming such status. Any nonprofit provider able to provide quality HIV care is given legislative preference over for-profit entities seeking to serve the same area.

**Sixty Percent Restriction
Limit**

The Fiscal Agent must ensure that Care Services Program monies do not comprise more than 60 percent of any subcontractor's total budget. Ryan White monies are not to be the sole source funding for any agency.

Subcontracts with Service Providers

The Fiscal Agent is responsible for ensuring that all Care Services Program contracts incorporate the requirements of the prime contract (Exhibit 13) that are relevant to the services provided by the subcontractor.

**RESPONSE TO
MANAGEMENT MEMOS**

Management Memorandums (MMs) are sent periodically throughout the year. MMs provide additional information and clarification regarding administration and use of the Title II Program funds. MMs may also request information or acknowledgement of program compliance within a limited time frame. Most often, MMs transmit information or request information that HRSA has requested from the OA. In order for OA to be in compliance with HRSA, this information must be submitted in a timely manner. It is VERY important that Fiscal Agents and/or service providers are cognizant of these time frames and respond by the requested due date. Failure to submit a response to MMs by the required date may result in a reduction in administrative monies.

**OVERSEEING AN
INCLUSIVE COMMUNITY
PLANNING PROCESS**

The Direct Services category of the CARE Act allows states to directly fund services in the absence of a consortium or when this approach is proven to be more beneficial to the delivery of services. OA directly contracts with local Fiscal Agents that provide or subcontract HIV services. Fiscal Agents are solely responsible for the completion of planning documents and other documents typically required of consortia. OA acknowledges the importance of public input in the development of local care plans and mandates that each Fiscal Agent convene an advisory group to assist in the development of planning documents once a year at a minimum. Advisory group volunteers are not required to file a Form 700 and the Fiscal Agent is not required to comply with the Bagley-Keene Open Meeting Act, and in most cases are not required to comply with the Brown Act.

Required Input

The development of an inclusive community input process is one of the highest priorities as fiscal agents begin making decisions regarding the development of local HIV service delivery plans and other documents. Our requirement that the public input process be developed with assistance from representatives of the community is to ensure that an input process is developed in a manner that takes into consideration the specific barriers that have impeded the community's ability to provide input in the past.

Fiscal Agents are required to collect input from the communities that are reflective of HIV/AIDS infected and affected populations (including historically underserved groups and subpopulations) in their jurisdiction. Please see Exhibit 18 for a listing of required community input.

Required Consultation

Fiscal agents are required by the Care Act legislation to consult with private, local, state and federal agencies. Please see Exhibit 19 for a listing of required consultation contacts.

Service Delivery Plan

HIV Service Delivery Plans provide a "roadmap" for the development of a system of care and a blueprint for the complex decisions that must be made about planning, developing and delivering comprehensive HIV services.

Fiscal Agents are required to develop Service Delivery Plans that encompass a three-year period. However, they may require annual adjustments to address trends in the epidemic, client needs, or the introduction of new program requirements. Please see Exhibit 20 for the requirements of the 2003-2007 Service Delivery Plan.

Needs Assessment

The legislation for Title II funding specifically requires Consortia to conduct a needs assessment. In areas where there are no Consortia, the Fiscal Agent, utilizing an advisory group, shall conduct a needs assessment. The HIV/AIDS Bureau neither requires nor expects grantees and planning bodies to conduct a full needs assessment each year. The effort is time consuming and can lead to “consumer fatigue,” as well as grantee and planning body overload. A two- or three-year needs assessment cycle is recommended, with a schedule for collecting updated information to support planning, priority-setting, and resource allocation activities. Epidemiologic data should be obtained and reviewed annually, information on new populations added, and special circumstances—such as the impact of advances in medical treatments on service needs—addressed promptly.

Needs assessment is a process of collecting information about the needs of persons living with HIV (PLWH) (both those receiving care and those not in care), identifying current resources (CARE Act and other) available to meet those needs, and determining what gaps in care exist. This requires obtaining information from multiple sources about current conditions – including problems/service needs and the resources/approaches being used to address these needs. Presented overall and for specific populations, findings should be used to prioritize service needs and develop strategies to address them.

CARE Act services are intended to fill gaps in care for PLWH, including assisting individuals to access and remain in care. CARE Act needs assessment identifies service gaps by reviewing the current continuum of care, access to care for affected populations, particular service issues such as the quality of care and barriers to care, and areas of unmet need. Key needs assessment tasks include:

- Identifying the HIV/AIDS client base, through an array of epidemiologic, co-morbidity, and

socioeconomic data as well as other needs assessment information obtained through such methods as surveys, focus groups, and individual interviews. This information can reveal who is affected by HIV/AIDS, their characteristics and needs, and access to health care through public and private health insurance.

- Identifying existing services available to PLWH through a resource inventory of available services and organizations and an assessment of provider capacity/capability to deliver HIV/AIDS care.
- Identifying gaps in service needs that CARE Act programs might address. These are revealed by comparing available services to identified needs, including analysis that results in identification of particular service needs for specific PLWH populations. Identification of unmet needs should examine, in particular, gaps in care for asymptomatic PLWH, individuals with symptomatic HIV disease and a generally higher level of service needs, and individuals who are infected but do not yet know their HIV status.

The results of a needs assessment are used by CARE Act planning bodies and Fiscal Agents to meet their legislative responsibilities and help ensure that available CARE Act dollars are used effectively. This includes:

- Establishing service priorities;
- Providing guidance on how best to meet these priorities;
- Doing comprehensive planning for a continuum of care;
- Documenting the need for specific services and gaps in care;
- Providing baseline data for evaluation; and
- Helping providers improve service access and quality.

Needs assessment is the cornerstone of the CARE Act planning process. Needs assessment provides the information required to develop a service plan, set

priorities, and allocate available resources appropriately.

HRSA developed a Needs Assessment Guide to assist the CARE Act community in planning and conducting needs assessment. Included in the guide is information on assessing unmet need, a focus for the CARE Act of 2000. To request a copy of this manual call HRSA at (888) ASK-HRSA, [(888) 275-4227] or visit their website at www.hab.hrsa.gov/tools/needs.

HRSA's HIV/AIDS Bureau (HAB) sends via e-mail, technical assistance and primary care updates for the CARE Act community. To subscribe, contact Paula Jones at pjones1@hrsa.gov.

AUDIT REQUIREMENTS

A-133 Audit Requirements

The Federal Office of Management and Budget's (OMB) Circular No. A-133 – Revised June 24, 1997, Audits of States, Local Governments, and Non-Profit Organizations, sets forth standards for obtaining consistency and uniformity among federal agencies for the audit of states, local governments, and non-profit organizations expending federal awards. OMB Circular No. A-133 states that non-federal entities (state, local government, or non-profit organization) that expend \$300,000 or more in a year in federal awards shall have a single or program-specific audit conducted for that year. Exhibit A(F) in the contract between the Fiscal Agent and OA, requires that the audit be completed by the 15th day of the fifth month following the end of the contractor's fiscal year. Exhibit A(F) also requires that **within 30 days** after the completion of the audit, **two copies of the audit report must be sent to OA**. A copy of OMB Circular No. A-133 may be obtained by contacting the Office of Administration, Publications Office, Room 2200, New Executive Office Building, Washington, DC 20503 at (202) 395-7332.

DHS Audits

OA utilizes the Department of Health Services, Financial Audits Section, to conduct an audit of any entities receiving Title II CARE Act Program funds. Higher priority for audit is given to agencies receiving significant monitoring findings or upon closeout of a contract with OA.

ADMINISTRATIVE FUNDS

**Administrative Funding
Restrictions**

Fiscal Agents may receive up to ten (10) percent of the total grant amount for administration of the Title II CARE Act Program. This allocation includes the administration and monitoring for:

- Development of applications for funds
- Receipt and disbursement of program funds
- Development and establishment of reimbursement and accounting systems
- Preparation of routine programmatic and financial reports
- Compliance with grant conditions and audit requirements

Upon written request to OA, Fiscal Agents may receive up to five (5) percent of the total grant amount for the development, implementation, and evaluation of a needs assessment.

**Indirect and Operating
Expenses**

Fiscal Agents may use up to 10 percent of the total grant amount for administration of the Care Services Program. This allocation includes indirect and operating expenditures.

Indirect Expenses

Those expenses that cannot be assigned to one program. Often this category is used when a service provider administers multiple programs and funding sources and divides the rent, utilities, office supplies, janitorial services, etc., either equally among programs or based on the percentage of time spent on a program. Indirect expenses are limited to 15 percent of the total personnel costs.

Operating Expenses

Operating expenses are typically those expenses that can be assigned to a specific program but are not dedicated to providing the service. For example, a case manager who travels to see clients. The travel expense is part of that service, not an operating expense. Budgeting travel for state-required training would be an operating expense. Operating expenses might include office supplies, postage, telephone, etc.

PROGRAM EVALUATION

There are four broad areas that are critical to the successful delivery of HIV care in the United States today and responsive to the priorities of the 2000 reauthorized Ryan White CARE Act:

Meet Emerging Needs

- To what extent are CARE Act programs identifying individuals who are HIV+ but not in primary health care? What strategies are successful in getting PLWH to enter care earlier in the course of infection?
- To what extent are CARE Act local planning and decision-making processes adapting to (1) the needs of emerging communities and (2) a contracting service and reimbursement environment?

Access to Quality HIV/AIDS Care

- To what extent are CARE Act programs effective stewards of public HIV/AIDS care and treatment funds?
- To what extent are CARE Act clients receiving general PHS standards of care? What CARE Act services are most effective in improving client quality of life?
How can CARE Act programs integrate outreach, prevention and care to reduce new infections?

Evaluate the Impact of CARE Act Funds

- To what extent are CARE Act programs demonstrating results?
- To what extent are CARE Act programs making a unique contribution towards addressing HIV/AIDS?
- To what extent are CARE Act programs reducing morbidity and mortality associated with HIV/AIDS?

Coordinate CARE Act with Other Health Care Delivery Systems

- How can CARE Act programs reduce disparities in treatment (including access to and adherence with pharmaceutical regimens) for people who are in primary health care?
- How can CARE Act programs coordinate and strengthen systems of care within communities to assure access to and retention in care?

STANDARDS OF CARE

Standards of care are principles and practices for the delivery of health and social services that are accepted by recognized authorities and used widely. Standards of care are based on specific research (when available) and the collective opinion of experts.

QUALITY MANAGEMENT (QM)

Grantees must ensure that contractors/subcontractors have quality management (QM) programs in place. Through QM efforts, service providers should be able to identify problems in service delivery that may affect health status outcomes at the client and system levels. Evidence of QM activities should be included in contract language with service providers, site-visit protocols, and the monitoring tools and processes used by the grantee. Further guidance and QM references are available at www.hab.hrsa.gov/tools/qm.

QUALITY ASSURANCE

Quality Assurance involves identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

**CONTINUOUS QUALITY
IMPROVEMENT (CQI)**

CQI is an ongoing process that involves service providers in ongoing activities to continuously improve service delivery. Activities include monitoring and evaluating inputs, processes, outputs, and outcomes. In contrast to quality assurance, which focuses on identifying and solving problems, CQI seeks to prevent problems and to maximize the quality of care. Steps in the CQI process include the following:

1. **Plan** – Identify problems (including their components—not just the big picture) and then plan strategies/tests that might result in improvements.
2. **Do** – Use strategies/tests that are designed to address problems.
3. **Study** – Collect and analyze data to see if strategies have resulted in improvements.
4. **Act** – If the strategies are effective, make them an ongoing activity. If they are not effective, return to the Plan stage. Use collected data to identify new ways to address problems.

**DEBARMENT AND
SUSPENSION
CERTIFICATION**

Exhibit D(F), paragraph 19 in the CSP contract requires that Fiscal Agents not contract with agencies or individuals who are under suspension or debarment by the Federal Government.

Components of compliance are:

- Signing your contract certifies that you will check all providers prior to contracting to ensure that they are not on the federal suspension and debarment list.
- Checking your contractors to be sure they are not on this list can be done by checking the *Medi-Cal Suspended and Ineligible Provider List* (S & I List) which is updated monthly and is available on the Internet at www.medi-cal.ca.gov. Please see the S&I List by clicking the "Publications" link, the appropriate "Provider Manual" link and then the "Online-Only Sections" link on the Medi-Cal website. Providers may view or download the S&I List in Microsoft Word format. Providers may also order a hard copy update of the section by calling the Telephone Service Center (TSC) at 1-800-541-5555. The Office of Inspector General Excluded Provider List is also available at www.oig.hhs.gov. Cross-referencing both lists is recommended to help identify providers who have already been suspended or sanctioned.
- Document and date your website findings. For example, "John's Food Wagon checked on Medi-Cal website 10/3/03; no debarments or suspensions."
- The documentation will be reviewed during CSP on-site monitoring efforts.

**OVERVIEW OF SERVICE
PROVIDER
RESPONSIBILITIES**

- Deliver quality services, designated by the Fiscal Agent, to HIV/AIDS eligible clients
- Ensure client eligibility
- Comply with all components of the contract with the Fiscal Agent and applicable components of the contract between the Fiscal Agent and OA
- Implement and maintain an invoice system using standard accounting practices
- Establish, implement and evaluate a continuous quality improvement system
- Provide Fiscal Agent reports that are accurate and complete by requested due date
- Ensure that all clients who receive services use any and all available third party payer funds prior to using CARE Act funds
- Maintain appropriate client forms, including intake, budget worksheet, service plan, client rights and responsibilities and verification of client eligibility
- Ensure that CARE Act funds do not exceed 60 percent of the agency's budget or any subcontractor's budget
- Collect and maintain back-up documentation for all invoices submitted to the Fiscal Agent for payment (invoices are to be based on cost as stated in the service provider's application budgets)
- Receive Fiscal Agent approval of any budget revisions prior to billing
- Submit characteristics data to the Fiscal Agent as part of the annual application for Ryan White Title II funds and whenever changes occur
- Secure Fiscal Agent's approval prior to release of any publicity regarding the CARE Act
- Ensure confidentiality of all client records
- Inform clients of the availability of Partner Counseling and Referral Services (PCRS)
- Providers who use Care Services Program funds for Housing Services and Housing Related Services must document that funds are utilized in

coordination with other local, state and federal housing programs; a plan is in place to ensure a long-term permanent and stable living situation for the individual and/or family. In cases where the provision of housing services does not provide direct medical or supportive services, documentation of the necessity of housing services to enable the client to gain and/or maintain medical care must be recorded in the client's file.

APPLYING FOR FUNDS

OA annually prepares and transmits an application package to all Fiscal Agents. The package includes: guidelines on how to complete the application, forms to be utilized, a list of services that may be funded, and a list of Care Services Advisors and their assigned areas if you need technical assistance.

Service providers must accurately complete their budget sheets and submit them to the Fiscal Agent by the designated due date. If service providers have any questions on how to complete their budget sheets, they should contact their Fiscal Agent.

It is vital that the application be completed and returned to OA by the due date. Timely submission ensures time for each Care Services Advisor to review and approve the applications and the OA Contracts Unit to prepare and execute the new contract before the new year begins on April 1.

SIXTY PERCENT RESTRICTION LIMIT

Ryan White monies must not comprise more than 60 percent of any service provider's total budget. Ryan White monies cannot be the sole source funding for any agency.

COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS

The contract between the Fiscal Agent and service provider must incorporate the requirements of the prime contract (Exhibit 13) that are relevant to the services provided by the service provider.

ADVISORY GROUPS

Service providers are encouraged to participate in advisory groups convened by the Fiscal Agent. However, they must be cognizant of issues that could be considered to be a conflict of interest. HRSA defines conflict of interest as “an actual or perceived interest by a member in an action which results in, or has the appearance of resulting in, personal, organizational, or professional gain.”

ADMINISTRATIVE EXPENSES

Indirect Expenses

Those expenses that cannot be assigned to one program. Often this category is used when a service provider has multiple programs and divides the rent, utilities, office supplies, janitorial services, transportation, etc., either equally among programs or based on the percentage of time spent on a program. **Indirect expenses are limited to 15 percent of the total personnel costs.**

Operating Expenses

Those expenses that can be assigned to a specific program but are not dedicated to providing the service. For example, a case manager who travels to see clients. The travel expense is part of that service, not an operating expense. However, budgeting travel for a state-required training would be an operating expense. Operating expenses might include office supplies, postage, facilities operations, telephone, etc.

Equipment

The CARE Act limits equipment purchases. Contact the Fiscal Agent for information regarding a specific equipment request.

Administrative Support

Administrative support is defined as services provided that are not direct services to clients. For example, administrative costs would include:

- The Executive Director if that person does not provide direct service to clients. If the Executive Director provides services, the administrative portion must be split from the services portion.
- Accounting staff.

- Receptionist staff if that person does not provide direct service to clients. If the receptionist makes appointments for all people who come to the agency, including vendors, this is not a direct service.

Note: Fiscal Agents are required to submit a justification for administrative fees in excess of 25% claimed by subcontractors.

GRIEVANCE PROCEDURES

The best way to resolve grievances is to prevent them, by using clear and appropriate decision-making processes and using a variety of informal methods to resolve potential problems before they become grievances. Informal methods can save time and help to build positive relationships between clients and service providers. When grievances cannot be resolved informally, formal solutions may include reliance on a specified set of written grievance procedures and/or the use of outside mediators.

Each service provider should have a written set of procedures for resolving grievances. Having a grievance process in place provides an orderly and fair process for addressing dissatisfactions early and well. A grievance process also deters individuals from airing their complaints in ways that are detrimental, such as spreading false information or escalating a complaint in a public fashion.

CLIENT'S RIGHTS AND RESPONSIBILITIES

Each service provider must have a signed client's rights and responsibilities form in each client file. Establishing a client's rights and responsibilities form is an excellent way to clarify expectations. It delineates what the client can expect from the service provider and what the service provider expects from the client. Below are some of the items service providers include in their Client Rights and Responsibilities form. The client and the case manager both sign and date this form. You are **not required** to use these examples, they are provided as samples that you may wish to customize to meet

your agency's needs.

The client has the right to:

- Be treated with respect, compassion and sensitivity
- Receive services and benefits without discrimination of any kind
- Have all aspects of the care and services provided treated with privacy and confidentiality
- Participate in developing their plan for services
- Have the service provider's confidentiality policy explained
- Make choices about to whom information is released to (with some exceptions)
- Be fully informed about all of the services available
- Be fully informed about the availability of HIV Partner Counseling and Referral Services
- Have grievance procedures explained
- Have complaints responded to in a timely manner with no risk of detrimental effect on services
- Refuse care and/or discontinue services at any time
- Be notified of any changes of services, termination of service, or discharge from the program

The client has the responsibility to:

- Treat agency staff and volunteers with respect and to refrain from abusive language and behavior in communicating with them
- Be an active participant in obtaining services and maintaining their own well being
- Notify us (the service provider) of any change to their address, phone number, health, financial or living situation
- Apply for all eligible benefits in 30 days
- Keep appointments or cancel in advance
- Respect the confidentiality of others
- Provide adequate information to insure appropriate services

- Provide feedback about the effectiveness of services from the service provider
- Bring any complaint or grievance to the attention of the case manager
- Allow their chart to be reviewed by the administrative agent to ensure that services are being provided and vouchers are being paid according to the standards set by the service provider

**CLIENT
RECORDS/CONFIDENTIALITY**

Service providers should complete and maintain accurate client records. Client information should be kept in the client's file and periodically updated. Client files must be kept for a minimum of three years following the date of final payment authorization.

Any record containing medical information with personal identifiers is considered a medical record. All medical records are confidential and must be secured as required by the federal and state regulations (Federal Health and Safety Code Title 42 and California Code of Regulations, Title II). A copy of the Federal Health and Safety Code Title 42 may be obtained on the Internet at www.gpoaccess.gov. To obtain a copy of the California Code of Regulations, Title II, contact West Group, Barclays Division, P.O. Box 95767, Chicago, IL 60694, (800) 888-3600.

DATA REPORTING

OA as grantee for Care Services Program funding, must comply with HRSA reporting requirements. Fiscal Agents are, therefore, required to submit reports, in a timely manner, to OA. Failure to submit these reports by the due date may result in a 10 percent reduction of administrative monies. Fiscal Agents receive their data from service providers. Therefore, it is crucial that service providers supply accurate data and in a timely fashion. Please see Chapter 3, page 14, of this manual for data reporting requirements.

The following are incorporated in this exhibit:

- Ryan White Comprehensive AIDS Resource Emergency (CARE) Act of 1990
- Amendments of 1996
- Amendments of 2000

Copies of these documents can be downloaded from the HRSA webpage at www.hab.hrsa.gov.

See the attached for:

- Consortia/CSP Name
- Service Areas
- Contract Number
- Primary Contacts
- Fiscal Agents

Contact your CSP Advisor for updated copies of these lists.

Directory of Title II CARE Direct Services/Consortia Contacts & Fiscal Agents			
SERVICE AREA BY COUNTY	DIRECT SERVICE/CONSORTIA NAME	PRIMARY PROGRAM CONTACT	PRIMARY FISCAL AGENT
Alameda/Contra Costa Counties(Oakland EMA) Karl Halfman	Oakland EMA HIV Health Services Planning Council 03-75901	Ronald Person Dir./ Lori Williams Prg Mgr Alameda County Health Care Services Office of AIDS (510-873-6523/Lori) 1970 Broadway, Suite 1130 Oakland, Ca. 94612 (510) 268-2396 Fax (510) 873-6555 e-mail: Ron.Person@acgov.org	Elenita DeLeon Alameda County Health Care Services Office of AIDS 1970 Broadway, Suite 1130 Oakland, Ca. 94612 (510) 873-6512 Fax (510) 873-6555 e-mail Elenita.Deleon@acgov.org
Amador/Calaveras Tuolumne Estella Kile	Sierra Health Resources 03-75932	Jerry Cadotte Sierra Health Resources 1168 Booster Way (P.O. Box 159) Angels Camp, Ca. 95222 (209) 736-6792, Fax (209) 736-6836 e-mail: jerry@sierrahealthresources.org	Jerry Cadotte Sierra Health Resources 1168 Booster Way (P.O. Box 159) Angels Camp, Ca. 95222 (209) 736-6792, Fax (209) 736-6836 e-mail: jerry@sierrahealthresources.org
Butte/Colusa/Glenn Sutter/Yolo/Yuba Counties Angie Ogaz	United Way of Butte/Glenn 03-75936	Melinda Larkin Project Manager No. California AIDS Consortium 680 Rio Lindo Avenue, #4 Chico, Ca. 95926 (530) 342-7898 FAX (530) 342-4931 e-mail: unitedway1@aol.com	W. Jay Coughlin Executive Director United Way of Butte & Glenn Counties P.O. Box 3829 Chico, Ca. 95927 (530) 342-7898 FAX (530) 342-4931 e-mail: unitedway1@aol.com
Fresno County Angie Ogaz	Fresno County Dept. of Community Health 03-75903	Sharol Lloyd-Gridiron Supervisor, Comm. Disease Specialist 1221 Fulton Mall Fresno, Ca 93721 (559) 445-3434 e-mail: slloyd-gridiron@co.fresno.ca.us	Jena Adams, HIV Testing & Couns. Coordinator Fresno Department of Community Health 1221 Fulton Mall, PO Box 11867, Zip (93775) Fresno, Ca. 93721 (559) 445-3434 FAX (559) 445-3459 e-mail: jadams@fresno.ca.gov
Humboldt / Del Norte Estella Kile	Humboldt County Department of Health & Human Services 03-75904	Winston Wheeler Humboldt County HIV/CARE Consort. 529 I Street Eureka, Ca 95501 (707) 441-4614 FAX (707) 445-6097 e-mail: wwheeler@co.humboldt.ca.us	Leslie Abbott Humboldt Co. Dept. of Public Health 529 I Street Eureka, Ca 95501 (707) 441-5435 FAX (707) 445-6097 Reception (707) 445-6200 e-mail:labbott@co.humboldt.ca.us
Imperial County Angie Ogaz	Imperial County Department of Health & Human Services 03--75905	Sabina Laveaga HIV/AIDS Program Coordinator Imperial County Public Health 935 Broadway (760-482-4908 temp) El Centro, Ca. 92243 (760) 482-4469 FAX (760) 352-9933 e-mail: sabinalaveaga@imperialcounty.net	Josefina Marcial Imperial County Health Department 935 Broadway El Centro, Ca. 92243 (760)482-4909 FAX (760) 352-9933 e-mail: JosefinaMarcial@imperialcounty.net
Inyo County Angie Ogaz	Inyo County Department of Public Health 03-75906	Sue Stoutenburg RN, HIV Programs Manager Inyo County Health & Human Services 1351 Rocking W Drive Bishop, CA 93514 (760) 873-3914 FAX (760) 878-0266 e-mail: sstouthhs@qnet.com	Dorothy J. Iseli - "DJ" Health & Prevention Svcs. Fiscal Supervisor Inyo County Health & Human Services 155 East Market Street, P.O. Drawer H Independence Ca., 93526 (760) 878-0041 Fax (760) 878-0266 e-mail djhsinyo@qnet.com

Directory of Title II CARE Direct Services/Consortia Contacts & Fiscal Agents			
SERVICE AREA BY COUNTY	DIRECT SERVICE/CONSORTIA NAME	PRIMARY PROGRAM CONTACT	PRIMARY FISCAL AGENT
Kings County Angie Ogaz	Kings County Health Department 03-75909	Jean Ellsworth, MSN, BSN, RN Kings County Health Department 330 Campus Drive Hanford, CA 93230 (559) 584-1401 x2578 FAX (559) 584-0482 e-mail: jellswor@co.kings.ca.us	Nancy Gerking, Fiscal Account Clerk Kings County Health Department 330 Campus Drive Hanford, Ca. 93230 Confidential FAX (559) 584-6034 (559) 582-2795 x2574 FAX (559) 589-0482 email: ngerking@co.kings.ca.us
Kern County (Connie) Contact Concepcion Campos (661) 868-0329 Stella Kile	Kern County Department of Public Health 03-75908 camposc@co.kern.ca.us	Dave Martin, Program Manager Kern County Health Department 1800 Mt. Vernon Avenue Bakersfield, Ca. 93305 (661) 868-0366 FAX (661) 868-0263 email: martind@co.kern.ca.us	Cosmas George, Senior Health Educator Kern County Health Department 1800 Mt. Vernon Avenue Bakersfield, Ca. 93305 (661) 868-0179 FAX (661) 868-0171 email: georgec@co.kern.ca.us
Lake County Karl Halfman	Mendocino Community Health Clinic 03-75912	Sandra Richards, MSN, RN Clinical Coordinator, Program Manager Mendocino Community Health Clinic 5335 Lakeshore Blvd. Lakeport, Ca 95453 (707) 262-3205 FAX (707) 263-1197 e-mail: srichards@mchcinc.org	Sandra Richards, MSN, RN Clinical Coordinator, Program Manager Mendocino Community Health Clinic 5335 Lakeshore Blvd. Lakeport, Ca 95453 (707) 262-3205 FAX (707) 263-1197 e-mail: srichards@mchcinc.org
Los Angeles County Stella Kile	Los Angeles County Commission on HIV Health Services Title I 03-75910	Mario J.Perez, Interim Director County of Los Angeles - OAPP 600 South Commonwealth Ave. 6th Floor Los Angeles, Ca. 90005-4001 (213) 351-8001 Fax (213) 387-0912 e-mail mperez@dhs.co.la.ca.us	Monique Collins County of Los Angeles - OAPP 600 South Commonwealth Ave. 6th Floor Los Angeles, Ca. 90005-4001 (213) 351-8374 Fax (213) 351-8120 e-mail mcollins@ladhs.org
Madera County Angie Ogaz	Madera County Health Department 03-75911	Anne Harris Madera County Department of Public Health 14215 Road 28 Madera, CA 93638 (559) 675-7626 x266 FAX (559) 675-4943 e-mail: aharris@madera-county.com	Anne Harris Madera County Department of Public Health 14215 Road 28 Madera, Ca. 93638 (559) 675-7627x266 Fax (559) 675-4943 e-mail aharris@madera-county.com
Mariposa County Angie Ogaz	John C. Freemont Hospital 03-75907	Gerry Roesbery John C. Fremont Hospital Health Care District P.O. Box 216 Mariposa, CA 95338 (209) 966-3631 FAX (209) 742-6749 e-mail: gerry.roesbery@jcfhospital.com	Gerry Roesbery John C. Fremont Hospital Health Care District P.O. Box 216 Mariposa, Ca. 95338 (209) 966-3631 Fax (209) 742-6749 e-mail gerry.roesbery@jcfhospital.com
Merced County Angie Ogaz	Merced County Health Department 03-75914	Karen Resner Merced County Dept of Public Health 260 East 15th Street Merced, Ca 95340 (209) 381-1206 e-mail: dfarmer@co.merced.ca.us	Magdalena Lara Merced County of Department of Public Health 260 East 15th Street Merced, Ca. 95340 (209) 381-1207 Fax (209)381-1215 e-mail mlara@co.merced.ca.us
Mendocino County Public Health Karl Halfman	Mendocino County Public Health 03-75913	Rosalie Anchordoguy, Pgm Coordinator Mendocino County Dept. of Public Health 221 B South Lenore Avenue Willits, CA 95490 (707) 456-3806 FAX (707) 456-3808 e-mail: anchordr@co.mendocino.ca.us	Rosalie Anchordoguy, Program Coordinator Mendocino County Dept. of Public Health 221 B South Lenore Avenue Willits, Ca 95490 (707)456-3806 FAX (707) 456-3808 e-mail: anchordr@co.mendocino.ca.us

Directory of Title II CARE Direct Services/Consortia Contacts & Fiscal Agents			
SERVICE AREA BY COUNTY	DIRECT SERVICE/CONSORTIA NAME	PRIMARY PROGRAM CONTACT	PRIMARY FISCAL AGENT
Mono County Angie Ogaz	Mono County Department of Public Health 03-75915	Lynda Salcido Public Health Director P.O. Box 3329 Mammoth Lakes, Ca. 93546 (760) 924-1830 FAX (760) 924-5467 e-mail: lyjt@aol.com	Kat Robles Mono County Health Department P.O. Box 476 / 185 Twin Lakes Road Bridgeport, Ca. 93517 (760) 932-5587 FAX (760) 932-5284 e-mail: krobles@mono.ca.gov
Monterey County Stella Kile	Monterey County Health Department (Beginning 7/01/05) 05-45912	Ethan H Brown, HIV Programs Coordinator Monterey County Health Department 1292 Olympia Avenue Seaside, Ca. 93955 (831) 899-8209 Fax (831) 392-0479 e-mail: browneh@co.monterey.ca.us	Carol Corpus, Finance Manager II Monterey County Health Department 1270 Natividad Road, Room 5 Salinas, Ca. 93906 (831) 796-1250 FAX (831) 755-4565 e-mail: corpusc@co.monterey.ca.us
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Orange County Estella Kile	Orange County HIV Planning Advisory Council Title I 03-75920	Julie Webster, Program Manager Orange County Health Care Agency 1719 W. 17th St. Santa Ana, CA 92706 e-mail: jwebster@hca.co.orange.ca.us (714) 834-8063 Fax (714) 834-8270	Donna Flemming, Program Manager Orange County Health Care Agency 1725-B W. 17th Street Santa Ana, Ca. 92706 (714) 834-8405 Fax (714) 834-8727 e-mail: dflemming@ochca.com
Plumas/Sierra/Lassen Modoc/Siskiyou Karl Halfman	Plumas County Public Health Department 03-75921	Karla Burnworth Health Education Coordinator Plumas County Dept. of Health Services P.O. Box 3140 Quincy, Ca. 95971 (530) 283-6357 FAX (530) 283-6156 e-mail: karlaburnworth@countyofplumas.com	Rita Scardaci Director of Public Health County of Plumas P.O. Box 3140 / 1446 East Main Street Quincy, Ca. 95971 (530) 283-6337 FAX (530) 283-6425 e-mail: rscardaci@countyofplumas.com
Sacramento/Alpine El Dorado/Placer Angie Ogaz	Sacramento Area Consortium Title I 03-75922	Alan Lange, HIV Health Serv. Prog. Manager Community Services Planning Council 909 12th Street, Suite 200 Sacramento, Ca. 95814 (916) 447-7063 x360 Fax (916) 515-6731 e-mail: alange@communitycouncil.org	Adrienne Rogers, Health Program Coord. Sacramento County Health & Humans Serv. AIDS Service Programs 7001 - A East Parkway, Suite 600 Sacramento, Ca. 95823 (916) 875-6211 Fax (916) 875-5888 e-mail: rogersad@saccountry.net
San Benito County Estella Kile	San Benito County Health Department 03-75923	Kathy Flores, Director San Benito Co. Hlth. & Human Serv.Ag. 1111 San Felipe Road, Suite 102 Hollister, Ca. 95023 (831) 636-4180 FAX (831) 637-9754 e-mail: kflores@sanbenitohhsa.org	Marta Denice, Deputy Director San Benito County Health & Human Serv. 1111 San Felipe Road, Suite 207 Hollister, Ca. 95023 (831) 636-4180 FAX (831) 637-9754 e-mail: mdenice@sanbenitohhsa.org

Directory of Title II CARE Direct Services/Consortia Contacts & Fiscal Agents			
SERVICE AREA BY COUNTY	DIRECT SERVICE/CONSORTIA NAME	PRIMARY PROGRAM CONTACT	PRIMARY FISCAL AGENT
San Bernardino / Riverside	Inland Empire HIV Planning Council Title I 03-75924	Eric Frykman, M.D., MPH Health Officer (Interim Pgm Mgr) San Bernardino Co. Dept of Public Hlth. 505 N. Arrowhead Avenue San Bernardino, Ca 92415-00028 (909) 387-6219 Fax (909) 387-6228 e-mail efrykman@dph.sbcounty.gov	Daniel Perez, MSW Public Health Program Coordinator San Bernardino Co Dept of Public Health 1280 Cooley Drive, Ste. C Colton, Ca. 92324 (909) 876-3952 Fax (909) 872-1505 e-mail dperez@dph.sbcounty.gov
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Angie Ogaz			
City & County of San Francisco Marin, & San Mateo	HIV Health Services Planning Council Title I 03-75926	Brenda Walker Director - Budget & Finance, AIDS Office Department of Public Health AIDS Office 25 Van Ness Avenue Ste. 500 San Francisco, CA 94102 (415) 554-9495 Fax (415) 554-9495 e-mail: bwalker@dph.sf.ca.us Suzanne Wang 415-554-9009 (budgets)	Michelle Dixon Director, HIV Health Serv. AIDS Office Department of Public Health 25 Van Ness Avenue Ste. 500 San Francisco, CA 94102 (415) 554-9043 Fax (415) 431-7547 e-mail: michelle_dixon@dph.sf.ca.us
Karl Halfman			
San Joaquin County	San Joaquin County Health Department 03-75927	Vacant Title II Coordinator Public Health Services, San Joaquin Co. P.O. Box 2009 Stockton, Ca. 95201-2009 (209) 468-3861 FAX (209) 468-3495 e-mail:randerson@phs.hs.co.san-joaquin.ca.us	Geneva Bell-Sanford, MSW AIDS Program Coordinator Public Health Services, San Joaquin Co. P.O. Box 2009 Stockton, Ca. 95201-2009 (209) 468-3891 FAX (209) 468-3495 e-mail:gsanford@phs.hs.co.san-joaquin.ca.us
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Karl Halfman			
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Karl Halfman			
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Estella Kile			

Directory of Title II CARE Direct Services/Consortia Contacts & Fiscal Agents			
SERVICE AREA BY COUNTY	DIRECT SERVICE/CONSORTIA NAME	PRIMARY PROGRAM CONTACT	PRIMARY FISCAL AGENT
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Estella Kile			
Shasta/Trinity/Tehama CANCELLED CONTRACT United Way is FA until Oct. 1 for Shasta/Trinity Tehema County Hlth as of July 1, 2005 stands alone Angie Ogaz	New Contractor as of September United Way Acting as Fiscal Agent from 4/1/05 to 10/01/05 03-75919 Tehame 05-45913	Deanna Gee, Assist. Exec. Director Tehema County Health Serv. Agency 1860 Walnut Street / P.O.Boc 400 Red Bluff, Ca 96082 (530) 527-8491 x 3058 Fax (530) 527-0240 e-mail: geed@tcha.net	Cathy Croce, RN,PHN Tehema County Health Serv. Agency 1860 Walnut Street / P.O.Boc 400 Red Bluff, Ca 96082 (530) 527-6824 Fax (530) 527-0362 e-mail: crocec@tcha.net
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Sonoma County Commission on AIDS/HIV CARE Consortium Title I	Sonoma County 03-75934	Claire Etienne Sonoma Co. Dept. of Health Services AIDS Unit 499 Humboldt Street, #106 Santa Rosa, Ca. 95404 (707) 565-4629 Fax (707) 565-4637 e-mail: cetienne@sonoma-county.org	Joyce Hall (Temporary) AIDS Section Manager County of Sonoma Dept of Health Services, AIDS Unit 499 Humboldt Street, #106 Santa Rosa, Ca. 95403 (707) 565-4700 Fax (707) 565-7849 e-mail: jhall@sonoma-county.org
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Stanislaus County	Doctors Medical Center Foundation 03-75602	Carolyn Crown, Assistant Executive Director Doctors Medical Center Foundation 730 McHenry Avenue Modesto, Ca. 95350 (209) 527-3412 FAX (209) 527-1512 e-mail: ccrown@dmcf.org	Pam Chavez Doctors Medical Center Foundation 730 McHenry Avenue Modesto, Ca. 95350 (209) 527-3412 FAX (209) 527-1512 e-mail: pchavez@dmcf.org
Angie Ogaz			
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Karl Halfman			

Positions are currently being filled for Care Service Advisor. For a current listing of Care Service Advisors and their assigned areas, either:

- Contact Eileen Harvey, Chief of the Care Section, at 916 449-5946, or
- Go to www.dhs.ca.gov/aids/programs/care/manual.htm and click on the "Advisor Assignment" link.

Service Category	Definition
HEALTH CARE SERVICES	
Ambulatory/Outpatient Medical Care	<p>Provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health and nutritional issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).</p> <p><i>Primary Medical Care for the Treatment of HIV Infection</i> includes the provision of care that is consistent with Public Health Service's Treatment guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.</p>
Drug Reimbursement Program	<p>Ongoing service/programs to pay for approved pharmaceuticals and or medications for persons with no other payment source. Subcategories include:</p> <ol style="list-style-type: none"> State-Administered AIDS Drug Assistance Program (ADAP). Authorized under Title II of the CARE Act and provides FDA approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medi-Cal. Local/Consortium Drug Reimbursement Program. A program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program. Medications include prescription drugs provided through ADAP to prolong life or prevent the deterioration of health. The definition <i>does not include</i> medications that are dispensed or administered

Service Category	Definition
	during the course of a regular medical visit or that are considered part of the services provided during that visit. If medications are paid for and dispensed as part of an <i>Emergency Financial Assistance Program</i> , they should be reported as such.
Health Insurance	A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health-insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Home Health Care	Provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.
Home Health Professional Care	Provision of services in the home by licensed health care workers, such as nurses.
Home Health Specialized Care	Provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.
Oral Health	Diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Hospice Services	<ol style="list-style-type: none"> Home-Based Hospice Care. Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting. Residential Hospice Care. Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

Service Category	Definition
Mental Health Services	Psychological and psychiatric treatment and counseling services to individuals with a diagnoses mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
Nutritional Counseling	Provision of nutrition education and/or counseling by a licensed/registered dietitian outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietitian should be provided under <i>Psychosocial support services</i> .
Rehabilitation Services	Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training services.
Substance Abuse Services-Outpatient	Provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Substance Abuse Services-Residential	Provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).
Treatment Adherence Services	Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

Service Category	Definition
SUPPORT SERVICES	
Buddy/Companion Service	Provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.
Child Care Services	Care for the children of clients provided when clients are attending medical or other appointments, Title-related meetings, groups, or training. NOTE: This does not include daycare while the client is at work.
Child Welfare Services	Family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of HIV-positive children about risks and complications, care-giving needs, and developmental and emotional needs of children.
Case Management	A range of client-centered services that links clients with health care, psychosocial and other services. Case management ensures timely and coordinated access to medically-appropriate levels of health and support services and continuity of care through ongoing assessment of the client's and other key family members' needs and personal support systems. This also includes inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan; and (4) periodic

Service Category	Definition
	reevaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.
Client Advocacy	Provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.
Day or Respite Care	Provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client.
Developmental Assessment/Early Intervention Services	Provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools.
Early Intervention Services	For Titles I and II are a combination of services that include outreach, HIV counseling, testing, referral and provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.
Emergency Financial Assistance	Provision of short-term payment for essential utilities and for medication assistance when other resources are not available.

Service Category	Definition
Food Bank/Home Delivered Meals/Nutritional Supplements	Provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.
Health Education/Risk Reduction	Provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. This includes the provision of information on medical and psychosocial support services and counseling, to help clients with HIV improve their health status.
Housing Assistance	This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for short-term or emergency housing must be linked to medical and/or healthcare or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.
Housing Related Services	Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.
Legal Services	Provide individuals with assistance related to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. Not included are any legal services that arrange for guardianship or adoption of children after the death of the normal caregiver.
Outreach Services	Programs which have as their principal purpose the identification of people with HIV disease so that they may become aware of and may be enrolled in care and treatment services (i.e., case finding). Outreach does not include HIV counseling and testing or HIV prevention education. Outreach programs must be planned and delivered in coordination with State and local HIV-prevention outreach program to avoid duplication of efforts, targeted to

Service Category	Definition
	populations known through local epidemiologic data to be at disproportionate risk for HIV infection, conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and designed with quantified program reporting that will accommodate local effectiveness evaluation.
Permanency Planning	Provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
Psychosocial Support Services	Provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other HIV-related services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers.
Referral for Health Care/Supportive Services	The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within a case-management system by professional case managers, informally through support staff, or as part of an outreach services program.
Referral to Clinical Research	Provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments – drugs, diagnostics, procedures, vaccines, and other therapies – are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research.
Transportation	Conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

Program Policy Guidance

1. **Eligible Individuals and Services for Individuals Not Infected with HIV:**
Formerly Policy No. 97-01 - First Issued: February 1, 1997 and Reissued June 1, 2000.
2. **Allowable Uses of Funds for Discretely Defined Categories of Services:**
Formerly Policy No. 97-02 - First Issued: February 1, 1997 and Reissued June 1, 2000.
3. **Outreach: HAB Policy Notice - 02-01 Use of Ryan White CARE Act Funds for Outreach Services,** May 16, 2002 replaced Policy No. 97-03 - First Issued: March 31, 1997 and Reissued June 1, 2000.
4. **Clarification of Legislative Language Regarding Contracting with For Profit Entities:** Formerly a "Dear Colleague Letter" First Issued March 6, 1997 to All Title I and II CARE Act Grantees - Reissued June 1, 2000.
5. **AIDS Drug Assistance Program: Eligibility and Formulary Parity and Uses of Funds:** Formerly Policy No. 97-04 - First Issued: April 2, 1997 and Reissued June 1, 2000.
6. **Clarification of DSS/HAB Guidance Regarding AIDS Drug Assistance Program: Administration, Eligibility and Cost-Savings:** Formerly a "Dear Colleague Letter" First Issued October 17, 1997 to All Title I and II CARE Act Grantees and Reissued Again in July, 1999 and June 1, 2000.
7. **Residence of Planning Council Members and Consortia Members:**
Formerly Policy No. 98-01 - First Issued: February 1, 1998 and Reissued June 1, 2000.
8. **Staff Training:** Formerly Policy No. 98-02 - First Issued: February 1, 1998 and Reissued June 1, 2000.
9. **Guidelines for Reimbursement of Individuals Serving on a Ryan White Title I Planning Council and/or Title II Consortium:** Formerly a Program Guidelines Memorandum - Issued in January of 1997 and 2000 and Reissued June 1, 2000.

Copies of these documents can be downloaded from the HRSA webpage at www.hab.hrsa.gov.

DSS Program Policy Guidance No. 1

Eligible Individuals and Services for Individuals Not Infected with HIV

Formerly Policy No. 97-01, First Issued: February 1, 1997

June 1, 2000

The principal intent of Titles I and II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is the provision of services to persons infected with the Human Immunodeficiency Virus (HIV), including those whose illness has progressed to the point of clinically defined Acquired Immune Deficiency Syndrome (AIDS). Grantees, planning councils, or consortia when setting and implementing priorities for allocation of funds may optionally define eligibility for certain services more precisely, but they may not broaden the definition of who is eligible for services. Grantees are expected to establish and monitor procedures to ensure that all providers verify and document client eligibility. This policy clarifies eligibility for services provided to individuals. It does not define eligibility for services, such as outreach, which are directed to groups of people or which seek to identify those who may become eligible for individual services.

Non-infected individuals may be appropriate candidates for CARE Act services in limited situations, but these services must always have at least indirect benefit to a person with HIV infection. Funds awarded under Title I or Title II of the Ryan White CARE Act may be used for services to individuals not infected with HIV only in the circumstances described below.

- a. The service has as its primary purpose enabling the non-infected individual to participate in the care of someone with HIV disease or AIDS. Examples include caregiver training for in-home medical or support service; and support groups, counseling, and practical support that assist with the stresses of caring for someone with HIV.
- b. The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include payment of premiums for a family health insurance policy to ensure continuity of insurance coverage for a low-income HIV+ family member, or child care for non-infected children while an infected parent secures medical care or support services.
- c. The service promotes family stability for coping with the unique challenges posed by HIV/AIDS. Examples include permanency planning for infected and uninfected children of HIV parents, mental health services which focus on equipping uninfected family members and caregivers to manage the stress and loss associated with HIV, and short-term post death bereavement counseling. Services to non-infected clients that meet this criteria may not continue

subsequent to the death of the HIV-infected family member beyond the period of short-term bereavement counseling and/or permanency planning for uninfected children.

DSS Program Policy Guidance No. 2

Allowable Uses of Funds for Discretely Defined Categories of Services

Formerly Policy No. 97-02, First Issued: February 1, 1997
June 1, 2000

This policy statement concerns the use of funds awarded under Title I or Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act for the provision of services to eligible individuals. Guidance regarding allowable uses of funds awarded under other Titles of the CARE Act must be obtained from the Federal program offices responsible for their administration.

Existing Federal Policy on Allowable Uses of Funds

The Office of Management and Budget (OMB) has developed cost principles and uniform administrative requirements for all organization types (State and Local governments, non-profit and educational institutions, and hospitals) in all Federally-funded programs. These are known as OMB Circulars, and are management directives to Federal agencies which they must in turn apply to all recipients. Fiscal officers for all grantees should be thoroughly familiar with all relevant Circulars. The grantee may be more strict in the administration of grant funds, but may not be more lenient. Grantees must further apply the requirements to sub-recipients, as noted, in each OMB Circular.

The cost principles permit an organization to establish and use its own accounting system to determine costs, provided it is based on sound accounting principles, consistently applied to all organization activities regardless of the source of funds supporting those activities. Recipients of Federal grant funds are expected to exercise the same degree of prudence in the expenditure of Federal funds as they use in expending their own funds.

Division of Service Systems Policies

DSS has developed program guidance policies which incorporate both OMB directives and program specific requirements. Grantees, planning groups, and others are advised that independent auditors, and auditors from the Office of the Inspector General of the Department of Health and Human Services may assess and publicly report the extent to which a grant is being administered in a manner consistent with program policies such as these. Grantees can expect oversight through DSS monitoring and review of budgets and contractors. DSS is able to provide technical assistance to grantees, planning councils, and consortia where assistance with policy compliance is needed.

Grantees are reminded that it is their responsibility to be fully cognizant of limitations on uses of funds as outlined in the Public Health Service (PHS) Grants Policy Statement (copies of which have been previously provided to every grantee; additional copies are

available from the Grants Management Branch at 301-443-2280). In the case of services being supported in violation of an existing Federal policy, (e.g., payment of home mortgages), the use of CARE Act funds must be terminated immediately and grantees may be required to return already-spent funds to the Federal government.

Further Guidance on Allowable Uses of CARE Act Funds

The CARE Act stipulates that "funds received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by sources other than Ryan White funds. At the individual client level, this means that grantees and/or their subcontractors are expected to make reasonable efforts to secure other funding instead of CARE Act funds whenever possible. In support of this intent, it is an appropriate use of CARE Act funds to provide case management or other services which have as a central function ensuring that eligibility for other funding sources (e.g., Medicaid or Medicare, other local or State-funded HIV/AIDS programs, or private sector funding, etc.) is aggressively and consistently pursued.

In every instance, DSS expects that no service will be supported with CARE Act Title I funds unless it (1) falls within the legislatively-defined range of services, and (2) has been selected as a local priority by the HIV Health Services Planning Council. In the case of Title II funds, services must fall within the legislatively-defined range of services and, in the case of allocations decisions made by a State or by a local or regional consortia, services must meet documented needs and contribute to the establishment of a continuum of care.

CARE Act funds are intended to support only the HIV-related needs of eligible individuals. Grantees, planning councils, and consortia should be able to make an explicit connection between any service supported with CARE Act funds and the intended recipient's HIV status, or care-giving relationship to a person with HIV/AIDS.

In no case may CARE Act funds be used to make direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers or similar programs, which may only be exchanged for a specific service or commodity (e.g., food or transportation), must be used to meet the need for such services. Grantees are advised to administer voucher programs in a manner which assures that vouchers cannot be readily converted to cash.

This general policy statement has been effective since February 1, 1997 and applies to all services provided to individuals, including those for which separate clarifying statements have been developed (see following pages). Any subsequent statements on other services will be individually dated, but will also be subject to all provisions on these pages. For clarification, or a copy of the most recent list of services governed by this policy, contact the Office of the Director, Division of Service Systems at 301-443-6745.

2.1 Benefits and Entitlement Counseling for Eligible Individuals

Funds awarded under Title I or II of the Ryan White CARE Act may be used for programs which assist CARE Act-eligible clients to secure access to other public and private programs for which they may be eligible.

2.2 Child Care for Eligible Individuals

Funds awarded under Titles I or II of the CARE Act may be used for child care in these instances:

- a. to support a licensed or registered child care provider for intermittent or continuing care of HIV+ children;
 - b. to enable an infected adult or child to secure needed medical or support services through
- (1) support to a licensed or registered provider of child care to infected or non-infected children, and/or
- (2) support for informal child care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to individuals to pay for these services).

In those cases where funds are allocated for child care of the type described under b.(2) above, such allocations should be limited and carefully monitored to assure compliance with the prohibition on direct payments to eligible individuals. Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision-making process.

2.3 Clinical Trials for Eligible Individuals

Definitions: Clinical trials are Food and Drug Administration (FDA)-approved controlled experiments of investigational agents or treatments, with costs typically shared by pharmaceutical manufacturers and government. The FDA initiated expanded access programs in 1989 as a mechanism for making promising new treatments available for those with life threatening diseases and no other treatment options. Compassionate use programs are a product of pharmaceutical companies which make investigational new pharmaceuticals available for the same group. Pharmaceutical companies sponsor both expanded access and compassionate use programs.

Funds awarded under Title I or II of the CARE Act may not be used to support the costs of operating clinical trials of investigational agents or treatments (to include administrative management or medical monitoring of patients).

Funds may be used to support clinical costs (exclusive of pharmaceuticals) of expanded access or compassionate use programs where efficacy data exist and where the FDA

has authorized such expanded use. Funds may also be used to support participation in clinical trials, and in expanded access and compassionate use programs.

2.4 Complementary Therapies for Eligible Individuals

Funds awarded under Title I or II of the CARE Act may be used to support specific services that are generally referred to as complementary therapies upon written referral by the client's primary health care provider (or substance abuse counselor in the case of referrals for acupuncture associated with substance abuse treatment). All complementary therapies are to be provided by certified or licensed practitioners and/or programs wherever State certification or licensure exists.

2.5 Developmental Services for HIV+ Children

Funds awarded under Title I or II of the CARE Act may be used to provide clinician prescribed developmental services for HIV+ infants/children when such services are not covered by specific State and Federal legislation that mandates health care coverage for all children with developmental disabilities.

2.6 Emergency Assistance for Eligible Individuals

Funds awarded under Title I or II of the CARE Act may be used to support emergency assistance in one of two ways. Planning councils, Title II grantees, or consortia - in making allocations to the service categories of transportation, food, housing, or medication assistance - may specify that some portion of those allocations is to be used for emergency assistance. Alternatively, planning councils or consortia may establish a separate category of emergency assistance in their priority setting processes. In such cases however, the decision-makers must deliberately and clearly delineate and/or monitor what part of the overall allocation to emergency assistance is obligated to transportation, food, housing (to include essential utilities), or medication assistance. Careful monitoring of expenditures within a category of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to indicate when reallocations may be necessary.

Grantees and planning councils/consortia are to develop standard limitations on the provision of CARE Act-funded emergency assistance to eligible individuals/households and mandate their consistent application by all contractors. It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of CARE Act funds to these purposes will be for limited amounts, limited use, and limited periods of time.

2.7 Funeral and Burial Expenses

Funds awarded under Title I or II of the CARE Act may not be used for funeral, burial, cremation, or related expenses.

2.8 Maintenance of Privately Owned Vehicles for Eligible Individuals

Funds awarded under Title I or II of the CARE Act may not be used for direct

maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees. This restriction does not apply to vehicles operated by organizations for program purposes. Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported with Title I or II funds, but should not in any case exceed the established rates for Federal programs. Federal Joint Travel Regulations provide further guidance on this subject.

Additional Allowable Uses of Funds for Discretely Defined Categories of Services

The following policy guidance additions (No. 2.9 through No. 2.23) were issued on February 1, 1998 as a supplement to this policy notice, as they also concern the use of funds awarded under Titles I or II of the CARE Act for the provision of services to eligible individuals. Program policy guidance regarding allowable uses of funds awarded under other Titles of the CARE Act must be secured from the respective Federal program offices responsible for their administration.

2.9 Legal Services for Eligible Individuals

Funds awarded under Title I or II of the Ryan White CARE Act should not be used for any criminal defense, or for class action suits unrelated to access to services eligible for funding under the CARE Act. CARE Act funds may be used for certain legal services directly necessitated by an individual's HIV/AIDS serostatus. These include:

- a. preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, etc.,
- b. bankruptcy proceedings, and
- c. interventions necessary to ensure access to benefits for which an individual may be eligible, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act.

2.10 Pastoral Counseling for Eligible Individuals

Funds awarded under Title I or II of the Ryan White CARE Act may be used for pastoral counseling services only if they are provided by institutional pastoral care programs (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers; or components of a larger service, such as home care or hospice, etc.). Programs are to be licensed or accredited wherever such licensure or accreditation is either required or available. Pastoral counseling services funded under Title I or II of the CARE Act are to be available to all individuals eligible for CARE Act services regardless of their religious or denominational affiliation.

2.11 Permanency Planning for Eligible Individuals

Funds awarded under Title I or II of the Ryan White CARE Act may be used for permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS. Permanency planning includes the provision of social service counseling or legal counsel regarding

(a) the drafting of wills or delegating powers of attorney, and (b) preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

2.12 Property Taxes

Funds awarded under Title I or II of the CARE Act may not be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).

2.13 Purchase of Non-Food Products for Use by Eligible Individuals

Funds awarded under Title I or II of the Ryan White CARE Act may be used to purchase non-food products, such as personal hygiene products, to be provided to eligible individuals through food and commodity distribution programs. CARE Act funds may not be used for household appliances, pet foods or products.

2.14 Recreational and Social Activities for Eligible Individuals

Funds awarded under Title I or II of the CARE Act may be used to support program expenses of adult and child day or respite care centers, and drop-in centers in primary or satellite facilities. Funds should not be used for off-premise social/recreational activities.

2.15 Substance Abuse Treatment for Eligible Individuals

- a. Outpatient Substance Abuse Treatment Services: Funds awarded under Title I or II of the Ryan White CARE Act may be used for outpatient drug or alcohol substance abuse treatment, including expanded HIV-specific capacity of programs if timely access to treatment and counseling is not available. Such services should be limited to:
 - (1) the pre-treatment program of recovery readiness;
 - (2) harm reduction;
 - (3) mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse;
 - (4) outpatient drug-free treatment and counseling;
 - (5) methadone treatment;
 - (6) neuro-psychiatric pharmaceuticals; and
 - (7) relapse prevention.
- a. Syringe Exchange: In accordance with Sec. 2678 and Sec. 422 of the CARE Act, as amended, funds may not be used for syringe exchange programs.
- b. Residential Substance Abuse Treatment Services: CARE Act funds may be used for residential substance abuse treatment programs, including expanded HIV-specific capacity of programs if timely access to treatment is not available. The following limitations apply to use of CARE Act funds for residential services:

- (1) Because of the CARE Act limitations on inpatient hospital care [see Sec. 2604.(b)(1)(B) and Sec. 2613.(a)(2)(A)(B)], CARE Act funds may not be used for inpatient detoxification in a hospital setting.
- (2) However, if detoxification is offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital), CARE Act funds may be used for this activity.
- (3) If the residential treatment service is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose.

2.16 Vision Care for Eligible Individuals

Funds awarded under Title I or II of the Ryan White CARE Act may be used for optometric or ophthalmic services and purchase of corrective prescription eye wear that is necessitated by HIV infection.

2.17 Vocational, Employment, and Employment-Readiness Services

Funds awarded under Title I or II of the CARE Act may not be used to support employment, vocational rehabilitation, or employment-readiness services.

2.18 Clothing

Funds awarded under Titles I or II of the CARE Act may not be used for purchase of clothing.

2.19 Day or Respite Care for Eligible Individuals

Funds awarded under Titles I or II of the CARE Act may be used for day care or respite care in the following instances:

- a. to support a licensed or registered provider of continuing day care for HIV+ adults or children;
- b. to enable an infected adult or child to secure needed medical or support services through: (1) support to a licensed or registered provider for day care for an infected adult; or, (2) support for informal adult day care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to an eligible individual to pay the neighbor or family member for this service); and/or,
- c. to provide periodic and time-limited respite for the caregiver(s) of infected adults or children which is necessary to support the caregiver in continuing those responsibilities.

In those cases where funds are allocated for care of the type described under b(2) above, such allocations should be limited and carefully monitored to assure compliance with the prohibition on direct payments to eligible individuals. Such arrangements may

also raise liability issues for the funding source which should be carefully weighed in the decision-making process.

2.20 Health Insurance Co-payments and Deductibles for Eligible Individuals

Funds awarded under Titles I or II of the CARE Act may be used to pay for public or private health insurance co-payments and deductibles for low-income individuals only. Consistent with the CARE Act, "low income" is to be locally defined.

2.21 Hospice Care for Eligible Individuals

Funds awarded under Titles I or II of the CARE Act may be used to pay for hospice care by providers licensed in the State in which services are delivered. Hospice services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice care to terminal patients. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling in the DSS Glossary of HIV Related Services. Palliative therapies must be consistent with those covered under the State Medicaid program.

2.22 Transportation for Eligible Individuals

Funds awarded under Titles I or II of the CARE Act may be used to provide transportation services for an eligible individual to access HIV-related medical or support services. Transportation should be provided through:

- a. a contract(s) with a provider(s) of such services;
- b. voucher or token systems;
- c. use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); or
- d. purchase or lease of organizational vehicles for client transportation programs.
[See also Policy No. 2.8 above, *Maintenance of Privately Owned Vehicles*, for further information.]

2.23 Water Filters for Eligible Individuals

Funds awarded under Titles I or II of the CARE Act may be used to purchase water filtration/ purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) in communities/areas where recurrent problems with water purity exist. Such devices (including their replacement filter cartridges) purchased with CARE Act funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron. This policy does not permit installation of permanent systems for filtration of all water entering a private residence.

Policy Notice - 02-01, The Use of Ryan White CARE Act Funds for Outreach Services and Q & A

Document Title: Use of Ryan White CARE Act Funds for Outreach Services

DATE: May 16, 2002

TO: All Ryan White CARE Act Grantees

Enclosed is the HIV/AIDS Bureau policy describing the use of the Ryan White CARE Act funds for outreach services. This policy reflects the changes in the Ryan White CARE Act Amendments of 2000 and establishes new guidelines for allowable expenditures for outreach services for all of the Titles, except for the Special Projects of National Significance (SPNS) Program.

A separate question and answer (Q & A) document on the Use of CARE Act Funds for Outreach Services is included to assist CARE Act grantees, and their planning bodies and contractors, in developing effective implementation strategies in compliance with the policy.

If you have any questions regarding the content of the HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

/s/

Deborah L. Parham, Ph.D., R.N.
Acting Associate Administrator

Enclosures

Health Resources and Services Administration

HIV/AIDS Bureau

Use of Ryan White CARE Act Funds for Outreach Services

Introduction

This policy reflects the provisions in the Ryan White Comprehensive AIDS Resources Emergency Act (CARE) Amendments of 2000, replaces "Division of Service Systems (DSS) Program Policy Guidance No. 3: Outreach, June 1, 2000" (formerly Policy No. 97-03, March 31, 1997), and establishes new guidelines for allowable expenditures for

outreach services. The purpose of all Ryan White CARE Act funds is to ensure that eligible HIV-infected persons gain or maintain access to HIV-related care and treatment. The new requirements give grantees increased flexibility in providing outreach services that are designed to identify persons at high risk for HIV, to bring HIV-infected persons into care, and for the purpose of early treatment in order to provide an array of early intervention and prevention services. Outreach services include services to both HIV-infected persons who know their status and are not in care and HIV-infected persons who do not know their status and are not in care. The policy applies to all Titles and programs of the CARE Act, except for the Special Projects of National Significance (SPNS) Program, due to its innovative nature and search for better models of care.

Outreach Services Prior to the Ryan White CARE Act Amendments of 2000

Prior to the reauthorization of the CARE Act, Titles I to IV grantees were allowed to use funds to pay for outreach services with certain restrictions. As outlined in former DSS Program Policy Guidance, Title I and Title II grantees could use CARE Act funds for "outreach programs which have as their principal purpose identifying people with HIV disease so that they become aware of and may be enrolled in care and treatment services and receive related support services that enable them to remain in care." Titles I and II funds could not be used for outreach programs "which exclusively promote[d] HIV counseling and testing and/or which [had] as their purpose HIV prevention education." The policy also stated that grantees could not use funds for "broad-scope awareness activities about HIV services which target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.)."

Title III and Title IV had similar allowances and restrictions on the use of CARE Act funds for outreach services. According to their respective program guidances, Title III and Title IV grantees could use funds for outreach services to target high-risk individuals, who knew their HIV status, or if they did not know their HIV status, for counseling and testing and ultimately to link these individuals into care (that is, case finding). Grantees could not use funds for mass media campaigns or HIV prevention education efforts that did not include linking people into care, as described above. However, unlike Title I and Title II grantees, Titles III and IV grantees could use CARE Act funds to pay for counseling and testing services.

Outreach Services After the Ryan White CARE Act Amendments of 2000

On October 20, 2000, the Ryan White CARE Act Amendments of 2000 (Public Law 106-345) were enacted. These amendments reauthorized the CARE Act (Title XXVI of the Public Health Service Act) through 2005. The goal of the Amendments was to ensure that individuals living with HIV and AIDS receive health care and related support services. During the reauthorization process, the Congress paid close attention to significant changes in the HIV/AIDS epidemic and treatments that occurred between 1995 and 2000. In 2000, the CDC estimated that there were between 800,000 and 900,000 persons living with HIV disease in the United States, with 40,000 new

infections annually. CDC found that only approximately one-third of those individuals are in medical care, one-third know their HIV status but are not in medical care, and one-third do not know their HIV status. Early access to highly active antiretroviral therapy (HAART) and other care modalities reduces morbidity and mortality among persons living with HIV disease.

In 2002, CDC updated these estimates and found 850,000 to 950,000 persons are living with HIV/AIDS. The proportion of infected persons who know their status is increasing. CDC found that about 75 percent (670,000) have been diagnosed but a large proportion, approximately one-third, may not be receiving ongoing care. CDC indicates these two groups, persons diagnosed and undiagnosed, about 400,000 to 500,000 HIV-infected persons, may not have been tested, not receiving treatment or both.

In response to these and other trends, Congress placed a new emphasis on identifying and referring people with HIV disease into regular care and treatment, especially under Title I and II. The primary goal of this new emphasis was to improve early diagnosis of HIV and to enhance access to HIV care and treatment for persons infected or at high risk for HIV infection. The managers' statement that accompanied the CARE Act Amendments stated that, "[the] intent is to ensure that EMAs and States understand that outreach activities which are consistent with early intervention services and necessary to implement the linkage into care strategies, are appropriate uses of Titles I and II funds." (The Managers' Statement of Explanation, Congressional Record, October 5, 2000, pages H-8841 to 8844). It was not the Managers' intent that such activities supplant or duplicate activities such as case finding, surveillance and social marketing campaigns currently funded and administered by the CDC. Instead, the Managers' wanted to relay the urgency of increasing the coordination between HIV prevention and HIV care and treatment services.

New Outreach Service Guidance for Grantees

All CARE Act grantees, including Titles I and II grantees can now use funds to pay for HIV counseling and testing, outreach, and referral services. This policy clarifies what constitutes eligible outreach services for all Titles. In the provision of these services, grantees should target individuals who already know their HIV status, but are not receiving treatment. Vulnerable, high-risk HIV individuals who may or may not know they are HIV positive are often hesitant to seek care for various reasons (e.g., stigma, distrust of the health care system, lack of insurance, providers who lack cultural competence, etc.). Congress acknowledged the difficulties associated with outreach and recruitment among these individuals. In support of these efforts, the fiscal year 2001 appropriations to the Title II AIDS Drug Assistance Program (ADAP) provided \$7 million to support targeted education and outreach to vulnerable communities, including racial/ethnic minorities who are disproportionately impacted by the HIV/AIDS epidemic.

The goal of outreach services is to link individuals into care that would ultimately result in ongoing primary care and increased adherence to medication regimens. Outcome

measures need to be defined by grantees that reflect the goal to evaluate the success of outreach activities. Even with the changes in the CARE Act Amendments, it appears that broad activities such as providing "leaflets at a subway stop" or "a poster at a bus shelter" would not meet the intent of the law. This policy would give CARE Act grantees flexibility to target and identify individuals who may or may not know their HIV status and are not in care, have not returned for treatment services or do not adhere with treatment requirements.

Policy for Use of Ryan White CARE Act Funds for Outreach Services

Federal funds received under the Ryan White CARE Act, as established by Title XXVI of the Public Health Service Act, may be used for outreach activities which have as their principal purpose targeting activities, under specific needs assessment-based service categories, that can identify individuals with HIV disease. This includes those who know their HIV status and are not in care as well as those individuals whose HIV status is unknown, so that they become aware of the availability of HIV-related services and enroll in primary care, AIDS Drug Assistance Programs, and support services that enable them to remain in care.

Outreach activities supported with CARE Act funds must be:

- a. Planned and delivered in coordination with State and local HIV prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes;
- b. Directed to populations known, through local epidemiological data or through review of service data, to be at disproportionate risk for HIV infection;
- c. Conducted in such a manner, (i.e., time of day, month, events, sites, method, cultural appropriateness) among those known to have delayed seeking care relative to other populations, etc., and continually reviewed and evaluated in order to maximize the probability of reaching individuals infected with HIV who do not know their serostatus or know their status but are not actively in treatment;
- d. Designed to:
 - Establish and maintain an association with entities that have effective contact with persons found to be disproportionately impacted by HIV or disproportionately differ in local access to care, e.g., prisons, homeless shelters, substance abuse treatment centers, etc.
 - Direct individuals to early intervention services (EIS) or primary care (HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services).

- Include appropriately trained and experienced workers to deliver the message when applicable.

e. Designed to provide quantifiable outcome measures such as the number of individuals reached of previously unknown HIV status who now know they are positive, and/or the number of HIV positive individuals not in care who are now in care; and

f. Determined to be a priority service by Title I planning bodies and Title II consortia or State planning bodies, and be necessary to implement the EMA or State wide comprehensive plan and associated strategies.

Funds awarded under the CARE Act may not be used for outreach activities that exclusively promote HIV prevention education. Broad scope awareness activities that address the general public (poster campaigns for display on public transit, billboards, TV or radio announcements, etc.) may be funded provided that they are targeted and contain HIV information with explicit and clear links to health care services.

Outreach activities should supplement, and not supplant, such activities that are carried out with amounts appropriated under Section 317 of the Public Health Service Act, "Project Grants for Preventive Health Services" administered by the CDC or with other Federal, State or local funds.

The grantee must ensure that Ryan White CARE Act funds remain the payer of last resort.

Q & A on the Use of Ryan White CARE Act Funds for Outreach Services

1. What is an example of a targeted outreach service?

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds are intended for targeted outreach services to link persons with HIV who may or may not know their HIV status into care. Each grantee must determine who these persons are, where it is most likely these targeted services will reach intended individuals and result in them gaining access to, or maintaining in, HIV-related medical care or treatment. For example, a grantee could fund outreach workers to locate persons who tested positive and were informed of their test results but never returned for treatment. The grantee could use local epidemiological data to target HIV infected women with an appropriate media campaign that reaches this targeted audience and also informs them of the location and hours of a clinic in their area.

2. Can CARE Act funds be used in place of funds currently being used from local, State, and Federal agency for similar outreach program efforts?

CARE Act funds must be the payer of last resort. Funds used for outreach service must be used to supplement but not supplant funds currently used from local, State, and Federal agency programs. Similar outreach program efforts are defined as those efforts targeting persons with HIV who may or may not know their HIV status and are not in care.

3. If a grantee (or subgrantee) wants to begin an outreach effort targeting persons with HIV who may or may not know their status and are not in care, what must grantees have in place in order to proceed?

While HRSA/HAB policy does not specify all of the types of outreach services that can be funded with CARE Act funds, grantees and providers are responsible for utilizing Ryan White CARE Act funds for outreach activities and plans that have been approved in their grant award. Such plans, when submitted by grantees to HRSA must include in their budget and narrative:

- funding amount for outreach services;
- a description of outreach activities to be conducted along with a rationale for why these activities will identify persons with HIV not in care; and
- supporting data describing the need for such targeted outreach efforts.

In addition, grantees must develop outcome measures that include what their expected results are from such efforts.

3a. What are some examples?

These outcome measures are to be determined by the grantee. Here are examples of these types of output or performance measures. Grantees may also want to review the HRSA/HAB "Outcomes Evaluation Technical Assistance Guides" located on the Bureau's web site www.hab.hrsa.gov/tools/outcomeguides.htm. An outcome indicator or measure are observable, measurable data sets, that are used to track a program's success in reaching desired outcomes such as changes in CD4 counts over time that are used to track a program's success in reaching desired outcomes. Client-level outcomes are results or benefits for an individual client, including biological measures such as improved CD4 count or viral load. System level outcomes are results for all clients receiving services, such as reduced morbidity or mortality rates. Outputs are measures of the direct products or volume of program operations, such as the number of service units that a program delivers. A primary care example includes the number of clients served, CD4 and viral load tests completed, or specialty care consultation provided. For outreach, this measure may be tracking persons who get into care as a result of outreach and monitoring their clinical progress. Grantees must document achievements made in identifying and bringing persons into care through such outreach services.

4. Can grantees combine HIV prevention outreach activities with Ryan White CARE Act outreach activities?

HIV prevention outreach services funded through CDC, states, localities, and community based organizations are broader in scope, than RWCA funded outreach activities. The difference is in the scope, intent, and content of the message. CARE Act outreach is targeted to reach persons with HIV who may or may not know their HIV status and are not in care. CARE Act outreach services should be planned and delivered in a manner that: 1) targets outreach based on local needs assessment or epidemiologic data, to specific populations that are known to be at high risk or knowledgeable of their status, but not in care; and 2) establishes a "relationship or association" between the person targeted for the outreach and a program able to provide the service. While HIV broad based prevention outreach services can be co-located or coordinated with Ryan White CARE Act outreach programs, grantees' Ryan White CARE Act outreach activities must establish separate outreach planning, outcome measures, and financial accounting for their specific outreach activity.

5. The Ryan White CARE Act Amendments contained certain changes. Explain how to coordinate with points of entry, and early intervention services within my outreach activities under RWCA?

Points of Entry:

The Ryan White CARE Act Amendments of 2000 allow Title I and Title II to fund outreach services to link persons with HIV disease into care. This law also introduces language such as "key points of entry" (such as emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health program and homeless shelters) and "early intervention services" (HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services) where persons with HIV disease can be identified, referred, and maintained in health care and related supportive services. Grantees should coordinate outreach services such that they include key points of entry as sites where targeted outreach activities are conducted.

Early Intervention Services (EIS):

The grantee can use outreach to identify and refer individuals to new and existing early intervention services. Early intervention services stress the importance of bringing persons into care earlier in HIV disease progression. Outreach services are aimed at 1) identifying persons with HIV who may or may not know their status and are not in care; and 2) providing HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services. These

early intervention services are now eligible for all Titles under the Ryan White CARE Act.

6. Can grantees receive Technical Assistance (T/A) to implement this policy?

Grantees should discuss any outreach services T/A needs with their Project Officer who can provide technical T/A directly or determine if additional T/A is needed from other HRSA/HAB sources. The outreach plan must meet CARE Act legislative requirements and HRSA/HAB policy and guidance.

7. If I wanted to launch an outreach activity targeting persons with HIV who may or may not know their status and are not in care, what should I take into account in my program and other area providers?

CARE Act funds should be used for outreach services that are carefully planned by grantees to bring persons with HIV into care. The implementation of this policy is intended to ensure grantees carefully consider their outreach strategy before implementing any outreach services. In planning a potential outreach activity, the grantee should take into consideration the capacity of their programs to handle the estimated or increase in new clients. Grantees and providers are responsible for developing plans in coordination with other programs such that these programs know of the grantees effort to launch an outreach activity.

DSS Program Policy Guidance No. 4

Clarification of Legislative Language Regarding Contracting with For Profit Entities

Formerly a "Dear Colleague Letter" First Issued March 6, 1997 to
All Title I and II CARE Act Grantees
June 1, 2000

The CARE Act Amendments of 1996 provide for contracting with for-profit entities under certain limited circumstances. Specifically, the Amendments allow Title I and Title II funds to be used to "provide direct financial assistance" through contracts with "private for-profit entities if such entities are the only available provider of quality HIV care in the area." [SEC 2604(b))2)(A); SEC 2631(a)(1)]

This constitutes a formal clarification of legislative language by the Division of Service Systems, HIV/AIDS Bureau in consultation with the Grants Management Officer within the Bureau and with the Office of General Counsel of the Department of Health and Human Services, and is effective immediately.

Based on limitations contained in the CARE Act Amendments, grantees and other contracting agents must observe the following conditions in developing and implementing Requests for Proposals (RFP) and other local procurement procedures.

- a. Only available provider means that there are no nonprofit organizations able and willing to provide quality HIV service and that the grantee or other contracting agent is able to document this fact.
- b. Quality HIV care must be defined in a reasonable manner. Quality care **may not** be defined exclusively as a numerical score in an RFP process (i.e., all funds go to the highest scored proposal regardless of corporate status). An entity should only be deemed incapable of providing quality HIV care if written documentation of substantive quality of care deficiencies exists.
- c. Cost of service **may not** be the sole determinant in vendor selection processes whether internal or external (i.e., all funds go to the lowest bidder regardless of corporate status). However, grantees should not overlook cost considerations in developing and implementing RFP processes and are in fact expected to seek maximum productivity for each CARE Act dollar within the contracting limits of the legislation.
- d. Grantees must prohibit nonprofit contractors from serving as conduits who pass on their awards to for-profit corporations and **may** find it necessary to monitor

- membership of corporate boards in enforcing this prohibition. Federal Grants Management Policy is clear that the eligibility requirements that apply to first-level entities cannot be evaded by passing awards through to second- or subsequent-level entities that could not have received awards in the original competition.
- e. Proof of nonprofit status (local and/or State registration and approved articles of incorporation) should be required of all applicants claiming such status. Grantees are also strongly advised to require copies of letters of determination from the Internal Revenue Service.
 - f. A grantee or other contracting agent **may not** contract with both nonprofit and for profit entities for the same service in the same geographic area unless qualified nonprofit providers do not have the capacity to meet identified need. Any nonprofit provider able to provide quality HIV care is given legislative preference over for-profit entities seeking to serve the same area.

No new contracts may be executed after the date of issuing this notice (3/7/97) that violate these conditions on contracts with private for-profit organizations. Any contracts in place using funds awarded in fiscal year 1997 or later are in violation of this program policy guidance notice. Failure to comply with this requirement may result in required return of funds to the Federal government, suspension of grant awards, or other remedies deemed necessary.

Grantees and other contracting agents are encouraged to include in all RFP materials disclaimers which advise private for-profit organizations of the significant legislative barriers to their receiving contracts. Alternatively, and if local/State regulations and laws allow it, grantees may seek to define "qualified applicants" at the beginning of the process in a way which would save private for-profit organizations the time and effort needed to develop applications which could not be considered for funding.

Any questions about this program policy should be directed to the grantee's Project Officer.

DSS Program Policy Guidance No. 5

AIDS Drug Assistance Program: Eligibility and Formulary Parity and Uses of Funds

Formerly Policy No. 97-04, First Issued: April 2, 1997
June 1, 2000

Eligibility criteria for enrollment of persons living with HIV disease in a CARE Act-funded State AIDS Drug Assistance Program (ADAP), and treatments available on the approved ADAP formulary to enrolled individuals, must be equally and consistently applied across the State. If a State chooses to operate its ADAP through contracts to consortia or other entities, it must develop and implement procedures to monitor compliance with the requirement of consistent application of eligibility standards and formulary access.

Use of Federal Funds in State AIDS Drug Assistance Programs

Funds awarded under Title I or Title II of the CARE Act that are allocated for use by State AIDS Drug Assistance Programs (ADAPs) for therapeutics that treat Human Immunodeficiency Virus (HIV) disease or prevent the serious deterioration of health arising from HIV disease, and the ancillary devices (e.g., IV tubing, nebulizers, etc.) needed to administer these therapeutics, **may only** be used to purchase FDA-approved medications and the devices needed to administer them.

CARE Act funds that are allocated to ADAPs **may not** be used for laboratory or other diagnostic and monitoring tests and procedures such as radiographs, blood counts, or viral load testing. These services **may**, however, be paid for with CARE Act funds allocated by States, consortia, or planning councils to primary care or related categories of service.

Neither of the preceding limitations precludes use of CARE Act funds for ADAP administration costs within the legislative limits on such expenditures

DSS Program Policy Guidance No. 6

Clarification of DSS/HAB Guidance Regarding AIDS Drug Assistance Program: Administration, Eligibility and Cost-Savings

Formerly a "Dear Colleague Letter" First Issued October 17, 1997 to
All Title I and II CARE Act Grantees and Reissued in July, 1999

June 1, 2000

Background

A formal letter was sent to all grantees funded under Title I and Title II of the CARE Act in October 1996, concerning the administration of State AIDS Drug Assistance Programs (ADAPs). That letter contained recommendations for ADAPs regarding issues related to administration, eligibility, formularies and cost-savings. Several recommendations became formal program policy in April 1997 (please refer to DSS/HAB Program Policy No.5, "ADAPs: Eligibility and Formulary Parity and Uses of Funds.")

Subsequently, a second formal letter was issued to Title I and Title II grantees on July 7, 1999 which reiterated some of the remaining program guidance and recommendations from the October 1996 letter, that are critical to the successful management and administration of State ADAPs. They also help to insure that ADAPs are the payers of last resort, as mandated by the CARE Act. Therefore, DSS/HAB is re-issuing the contents of that letter as a formal clarification of program guidance and recommendations as they relate to ADAP administration, eligibility and cost-savings.

6.1 ADAP Administration

- a. States should consider establishing a centrally administered ADAP. It is the observation of the DSS/HAB that centrally administered ADAPs are better able to achieve accountability, parity, consistency and cost-savings than decentralized ADAPs.
- b. States subject to the matching requirement for Title II must match ADAP supplemental funds as well as Title II Base funds. The CARE Act as amended in 1996 requires Title II grantees (i.e., each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands and Guam) to maintain State expenditures for HIV-related activities at a level equal to the one year period preceding the fiscal year (FY) for which the grantee is applying to receive a Title II grant. Grantees are accountable to ensure that Federal funds do not displace State spending but instead expand HIV-related activities. For additional information on matching requirements, please see Maintenance of Effort: DSS Issue Paper released on October 17, 1997.

- c. The Department of Health and Human Services (HHS), in requesting the supplemental funds for ADAP, and the Congress, in appropriating them, clearly expect that Title II grantees use these funds to expand current efforts to improve access to pharmaceuticals for low-income individuals with HIV disease. Compelling reasons may exist or occur where ADAP supplemental funds supplant other funding sources (e.g., Title II base funds, Title I funds, etc.); however, the grantee should be prepared to document the rationale for making these changes in ADAP funding.

6.2 Eligibility

- a. The CARE Act indicates that ADAPs are to serve "low-income individuals," as defined by the States. The State's poverty criterion for ADAP eligibility should be based on Federal poverty guidelines.
- b. All States should devise, implement, and rigorously monitor the use of consistent eligibility standards across all entities involved in certifying and re-certifying ADAP eligibility. Such certification is expected to include review and documentation of an applicant's income from all sources and any pharmaceutical benefits derived from private health insurance or other sources.
- c. Every State should establish and implement procedures for ADAP client re-certification on a periodic basis, and for de-certifying individuals who qualify but have not utilized the program for a specific period of time (e.g., one year or longer). Re-certification procedures should include mechanisms to assure that individuals who have become eligible for Medicaid are transferred to the Medicaid program at the earliest possible date.

6.3 Cost-savings

- a. Both HHS and the Congress expect that States use every means at their disposal to secure the best price available for all products on their ADAP formularies in order to achieve maximum results with these funds.
- b. Every ADAP should adopt cost-saving strategies that will be equal to or greater than the cost savings realized with the Office of Drug Pricing's Section 340B Drug Discount Program which can be accessed by ADAPs through either the direct purchase discount or rebate option.

Any questions regarding this program policy guidance should be directed to the Chief, AIDS Drug Assistance Branch, Division of Service Systems, at 301-443-6745.

DSS Program Policy Guidance No. 7

Residence of Planning Council Members and Consortia Members

Formerly Policy No. 98-01, First Issued: February 1, 1998

June 1, 2000

The principal residence of Title I planning council members who represent affected communities, people with HIV, non-elected community leaders, or historically underserved groups and sub-populations must be within the geographic boundaries of the EMA for the length of the term in which they are serving on the council. In cases where a Title I planning council also serves as a Title II regional consortium and the consortium boundaries are larger than those of the EMA, residency requirements shall apply to the larger boundaries.

The principal residence of individuals filling legislatively-mandated organizational seats on Title I planning councils (health care providers, including federally qualified health centers; community-based organizations serving affected populations and AIDS service organizations; social service providers; mental health and substance abuse providers; local public health agencies; hospital or health care planning agencies; State government, including the Medicaid agency and Title II administering agency; other CARE Act grantees; and other Federal HIV programs) should be within the geographic boundaries of the EMA, but this is not required. It is recognized that this **may not** be possible for individuals representing the Title II administering agency and/or the State Medicaid agency. To qualify for organizational representation on a planning council, entities of the types named above must provide services within the boundaries of the EMA.

States are strongly encouraged to develop and monitor similar residency requirements for membership of Title II consortia.

DSS Program Policy Guidance No. 8

Staff Training

Formerly Policy No. 98-02, First Issued: February 1, 1998
June 1, 2000

Funds awarded under Titles I or II of the Ryan White CARE Act **may not** be used to pay for professional licensure or to meet program licensure requirements. Title I or Title II funds **may** be used to support specific HIV staff training which enhances an individual's or an organization's ability to improve the quality of services to affected clients.

DSS Program Policy Guidance No. 9

Guidelines for Reimbursement of Individuals Serving on a Ryan White Title I Planning Council and/or Title II Consortium

Formerly a Program Guidelines Memorandum. Issued in January of 1997 and 2000 June 1, 2000

The Public Health Service (PHS) Grants Policy Statement provides guidance on reimbursable costs to members of consumer/provider boards for participation in planning council consortium, and/or associated grantee meetings. The PHS policy allows for the reimbursement of reasonable and actual out-of-pocket expenses incurred by an individual solely as a result of attending a scheduled meeting.

The PHS Grants Policy Statement is the basis for these policies. Only planning council and consortia members are eligible for reimbursement of actual out-of-pocket expenses incurred as a result of attending scheduled meetings. Vouchers, flat rates, or other reimbursement structures that are not reimbursing for actual expenses are not allowable. Reasonable and out-of-pocket expenses include transportation, meals, babysitting fees, and lost wages. Funds for supplies, telephone, and facsimile charges must be included in the appropriate line item of the planning council or consortium budget.

When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state: 1) the percentage of the total costs of the program or project which will be financed with Federal money, 2) the dollar amount of Federal funds for the project or program, and 3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

**Guidance for Implementing Title I & Title II of the Ryan White CARE Act
U.S. DHHS, HRSA, HIV/AIDS Bureau, Division of Service Systems**

Invoices must be on agency letterhead in the approved format. See attached.

To obtain the Invoice Format as a Microsoft Excel file, go to
www.dhs.ca.gov/aids/programs/care/manual.htm and click on the "Forms" link.

Invoice Format Exhibit D

CARE SERVICES PROGRAM

OA Tracking #:

OA Date Stamp

Contractor Name

Mailing Address

(city, state and zip code)

03-
Contract Number

Period of Service (month / year)

		Amounts
A.	PERSONNEL	\$
B.	OPERATING EXPENSE	\$
C.	CAPITAL EXPENDITURES	\$
D.	OTHER COSTS	\$
E.	INDIRECT COSTS	
TOTAL INVOICE		\$ -
(LESS ADVANCE PAYMENT - if applicable)		\$ -
TOTAL AMOUNT PAYABLE		\$ -

I hereby certify that the amount claimed is accurate and a true representation of the amount owed.

Authorized Signature	Date
Print name of authorized signature	Title

OA Review:

(Initial & Date)

OA Review:

(Initial & Date)

FOR OA USE ONLY

Fiscal Year	PCA	Index	Object code	Agency Object	Project number		Work Phase

California Dept. of Health Services
Office of AIDS
MS 7700, P. O Box 997426
Sacramento, CA 95899-7426

(previous formats are obsolete)
CSP invoice form OA 04/04-05

Invoices must include an Invoice Detail form. See attached.

To obtain the Invoice Detail as a Microsoft Excel file, go to
www.dhs.ca.gov/aids/programs/care/manual.htm and click on the “Forms” link.

INVOICE DETAIL

Exhibit 7

Contractor

Contract No.

Address

City

Counties :

Fiscal Agent

Service Period: Mo. _____ Yr. ____

Contact Person

Provided Services HRSA Categories	Total Allocated	Expenditures To Date	Expenditures Current Month	Balance Remaining
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
Delivery Operations:				\$ -
Administrative				\$ -
Indirect/Operational/Equipment				\$ -
				\$ -
FISCAL AGENT COSTS:				\$ -
Administrative				
Operating Expenses				\$ -
Capitol Expenses				\$ -
Indirect Costs				\$ -
				\$ -
				\$ -
				\$ -
TOTAL	\$ -	\$ -	\$ -	\$ -

The Financial Status Report is one of three components of the mid-year and year-end reports. See attached.

To obtain the Financial Status Report as a Microsoft Excel file, go to www.dhs.ca.gov/aids/programs/care/manual.htm and click on the "Forms" link.

Financial Status Report

Contractor: _____

Exhibit 8

Reporting Period: _____ Contract Number: _____

Total Grant Award: _____

Service Provider (Subcontractor)	Total Contract	Expended To Date	Balance	Percentage Expended	Clients Served
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
			\$ -	#DIV/0!	
Needs Assessment			\$ -	#DIV/0!	
Fiscal Agt. Admin. Costs			\$ -	#DIV/0!	
Total	\$ -	\$ -	\$ -	#DIV/0!	

Financial Status Report

Contractor: _____

Exhibit 8

Reporting Period: _____ Contract Number: _____

Total Grant Award: _____

Service Provider (Subcontractor)	Women (25 or older)	Infants (0 - 1 yr)	Children (1 - 12 yrs)	Youth (13 - 24 yrs)
WICY EXPENDITURES	Expended	Expended	Expended	Expended
Needs Assessment				
Fiscal Agt. Admin. Costs				
Total	\$ -	\$ -	\$ -	

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MO 20857

June 1999

Dear Colleagues:

There is no question that a lack of access to high quality health care and tremendous disparities in health outcomes for many Americans are a major problem for our Nation. In recognition of this, the Health Resources and Services Administration (HRSA) has adopted a goal of "100% access, 0% disparity" for all of our programs, including the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Simply stated, this means that we are redoubling our focus on achieving access to high quality health care for all persons living with HIV/AIDS and eliminating race, gender, and geographic disparities in health outcome.

We are writing to ask you to examine your own programmatic decisions and priorities in the light of this goal. Disparities in health outcome, lack of access to quality health care, pharmaceuticals, and other necessary services which allow people to access and remain in care continue to challenge all of us fighting for the lives of people living with HIV/AIDS. This is particularly important in light of the potential benefit that can be offered by high quality care and by appropriate use of new anti-retroviral regimens. The Ryan White CARE Act provides one of the only mechanisms whereby our "100% access, 0% disparity" goal can be achieved in the face of this epidemic.

HRSA believes it is essential, therefore, that services supported with CARE Act funds relate to this goal. In particular, social and support services should be designed to assist persons living with HIV/AIDS to overcome barriers to accessing and to sustain participation in health care services. We urge that services which do not meet this criteria not be prioritized for CARE Act funding.

We recognize that difficult decisions are made at all levels of the CARE Act program every day and we do not presume to know what exact package of services will best serve your particular community. Communities will ultimately decide for themselves how best to achieve "100% access and 0" disparities" for people living with HIV/AIDS. This request that you partner with us and examine your own efforts in light of HRSA's goals is intended, rather, to provide direction for local processes, focus program management, and to articulate a national context for the Ryan White Program. We stand prepared to offer technical assistance and support as you address these issues and intend to devote a considerable portion of our upcoming All Title meeting to these issues.

We look forward to strengthening our partnership with you to better meet our goal of "100% access, 0% disparities" for our most vulnerable citizens.

Sincerely,
Claude Earl Fox, M.D., M.P.H.
Administrator

The following is incorporated in this exhibit:

- Instructions for Completing the Ryan White CARE Act Data Report (CARE Act Data Report)

A copy of this document can be downloaded from the HRSA web site at www.hab.hrsa.gov.

Title II - Grants to States and Territories

Title II of the Ryan White CARE Act provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five newly eligible U.S. Pacific Territories and Associated Jurisdictions.* Title II also funds the AIDS Drug Assistance Program (ADAP) and grants to States for Emerging Communities—those reporting between 500 and 1,999 AIDS cases over the most recent five years.* Title II funds may be used to provide a variety of services, including:

- Ambulatory health care;
- Home-based health care;
- Insurance coverage;
- Medications;
- Support services;
- Outreach to HIV-positive individuals who know their HIV status;*
- Early intervention services;* and
- HIV Care Consortia, which assess needs and contracts for services.

Funding

In FY 2002, \$977.4 million in Title II funds was awarded, of which \$639 million was earmarked for the AIDS Drug Assistance Program (ADAP).

Base Title II grants are awarded to States and Territories using a formula that, historically, has been based on reported AIDS cases. HIV prevalence (AIDS cases and HIV infections that have not yet progressed to AIDS) will be used to calculate grants as soon as data are adequate for doing so*. CARE Act provisions also require that States with more than one percent of total AIDS cases reported in the United States during the previous two years must contribute a match with their own resources, according to a formula outlined in the legislation.

Additional Title II funds are “earmarked” for State AIDS Drug Assistance Programs (ADAPs), which primarily provide medications. Fundable services also include treatment adherence and support, as well as health insurance coverage with prescription drug benefits.* Three percent of the ADAP earmark is reserved for grants to States and Territories with severe need for medication assistance.*

- Title II supports \$10.0 million in supplemental grants to States for Emerging Communities—cities with between 500 and 1,999 reported AIDS cases in the most recent five years.*
- Title II supports \$7 million for the Minority AIDS Initiative to increase minority participation in ADAPs.
- For the first time, two newly eligible U.S. Pacific Territories (American Samoa and the Commonwealth of the Northern Mariana Islands) and three Associated Jurisdictions (the Republic of the Marshall Islands, the Federated States of

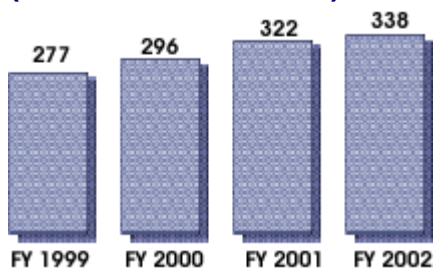
Micronesia, and the Republic of Palau) will each receive a \$50,000 Title II award.*

Providers

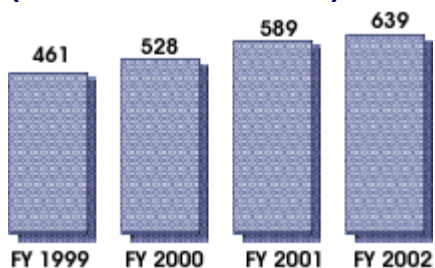
Title II providers may include public or nonprofit entities. For-profit entities are eligible only if they are the sole available providers of quality HIV care in the area.

Most States provide some services directly, while others work through subcontracts with Title II HIV Care Consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease.

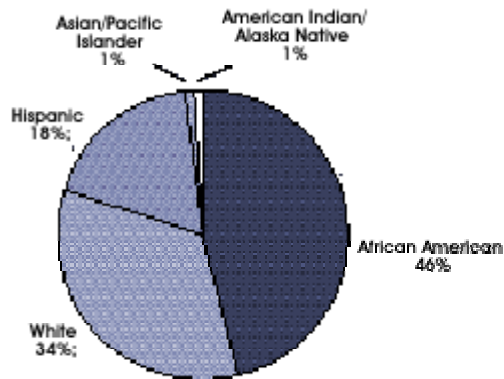
Ryan White CARE Act Title II Base Appropriations FY 1999–FY 2002 (in millions of dollars)



Ryan White CARE Act Title II ADAP “Earmark” FY 1999–FY 2002 (in millions of dollars)



Title II Clients by Race FY 2002



**Duplicated Title II Clients Served, by Support Service
FY 2002**

Outreach	26,397
Housing Assistance	29,662
Emergency Financial Assistance	40,870
Transportation	54,771
Counseling (Non-Mental Health)	51,693
Food Bank	68,364
Other	57,952
Client Advocacy	64,180
Education/Risk Reduction	45,819
Other Case Management	131,971

<p><u>April</u></p> <p>4/15 February invoice is due 4/30 4th quarter CADR is due</p>	<p><u>May</u></p>
<p><u>June</u></p> <p>6/15 year-end report is due 6/30 final invoice is due</p>	<p><u>July</u></p> <p>7/15 May invoice is due 7/31 1st quarter CADR is due</p>
<p><u>August</u></p> <p>8/15 June (or 1st quarter) invoice is due</p>	<p><u>September</u></p> <p>9/15 July invoice is due</p>
<p><u>October</u></p> <p>10/15 August invoice is due 10/31 2nd quarter CADR is due</p>	<p><u>November</u></p> <p>11/15 September (or 2nd quarter) invoice is due 11/15 mid-year report is due</p>
<p><u>December</u></p> <p>12/15 October invoice is due</p>	<p><u>January</u></p> <p>1/15 November invoice is due 1/31 3rd quarter CADR is due</p>
<p><u>February</u></p> <p>2/15 December (or 3rd quarter) invoice is due</p>	<p><u>March</u></p> <p>3/15 January invoice is due</p>

Your fully executed Care Services Program (CSP) contract is incorporated in this exhibit.

See attached sample.

CONTACTS FOR PCRS PROGRAM BY COUNTY

County	Contact	Phone Number
Alameda	Fern Orenstein	(510) 620-3190
Alpine	Enrique Coons	(916) 227-0454
Amador	Enrique Coons	(916) 227-0454
Butte	Enrique Coons	(916) 227-0454
Calaveras	Enrique Coons	(916) 227-0454
Colusa	Enrique Coons	(916) 227-0454
Contra Costa	Fern Orenstein	(510) 620-3190
Del Norte	Enrique Coons	(916) 227-0454
El Dorado	Enrique Coons	(916) 227-0454
Fresno	Raphael Reyes	(661) 868-0487
Glenn	Enrique Coons	(916) 227-0454
Humboldt	Enrique Coons	(916) 227-0454
Imperial	Raphael Reyes	(661) 868-0487
Inyo	Raphael Reyes	(661) 868-0487
Kern	Raphael Reyes	(661) 868-0487
Kings	Raphael Reyes	(661) 868-0487
Lake	Enrique Coons	(916) 227-0454
Lassen	Enrique Coons	(916) 227-0454
Los Angeles	Tony Bustamante	(213) 744-3369
Madera	Raphael Reyes	(661) 868-0487
Marin	Fern Orenstein	(510) 620-3190
Mariposa	Enrique Coons	(916) 227-0454
Mendocino	Enrique Coons	(916) 227-0454
Merced	Raphael Reyes	(661) 868-0487
Modoc	Enrique Coons	(916) 227-0454
Mono	Enrique Coons	(916) 227-0454
Monterey	Fern Orenstein	(510) 620-3190
Napa	Fern Orenstein	(510) 620-3190
Nevada	Enrique Coons	(916) 227-0454
Orange	Ayo James	(562) 570-4074
Placer	Enrique Coons	(916) 227-0454
Plumas	Enrique Coons	(916) 227-0454
Riverside	Raphael Reyes	(661) 868-0487
Sacramento	Enrique Coons	(916) 227-0454

County	Contact	Phone Number
San Benito	Enrique Coons	(916) 227-0454
San Bernardino	Raphael Reyes	(661) 868-0487
San Diego	Raphael Reyes	(661) 868-0487
San Francisco	Fern Orenstein	(510) 620-3190
San Joaquin	Enrique Coons	(916) 227-0454
San Luis Obispo	Raphael Reyes	(661) 868-0487
San Mateo	Raphael Reyes	(661) 868-0487
Santa Barbara	Raphael Reyes	(661) 868-0487
Santa Clara	Fern Orenstein	(510) 620-3190
Santa Cruz	Raphael Reyes	(661) 868-0487
Shasta	Enrique Coons	(916) 227-0454
Sierra	Enrique Coons	(916) 227-0454
Siskiyou	Enrique Coons	(916) 227-0454
Solano	Enrique Coons	(916) 227-0454
Sonoma	Enrique Coons	(916) 227-0454
Stanislaus	Enrique Coons	(916) 227-0454
Sutter	Enrique Coons	(916) 227-0454
Tehama	Enrique Coons	(916) 227-0454
Trinity	Enrique Coons	(916) 227-0454
Tulare	Enrique Coons	(916) 227-0454
Tuolumne	Enrique Coons	(916) 227-0454
Ventura	Raphael Reyes	(661) 868-0487
Yolo	Enrique Coons	(916) 227-0454
Yuba	Enrique Coons	(916) 227-0454

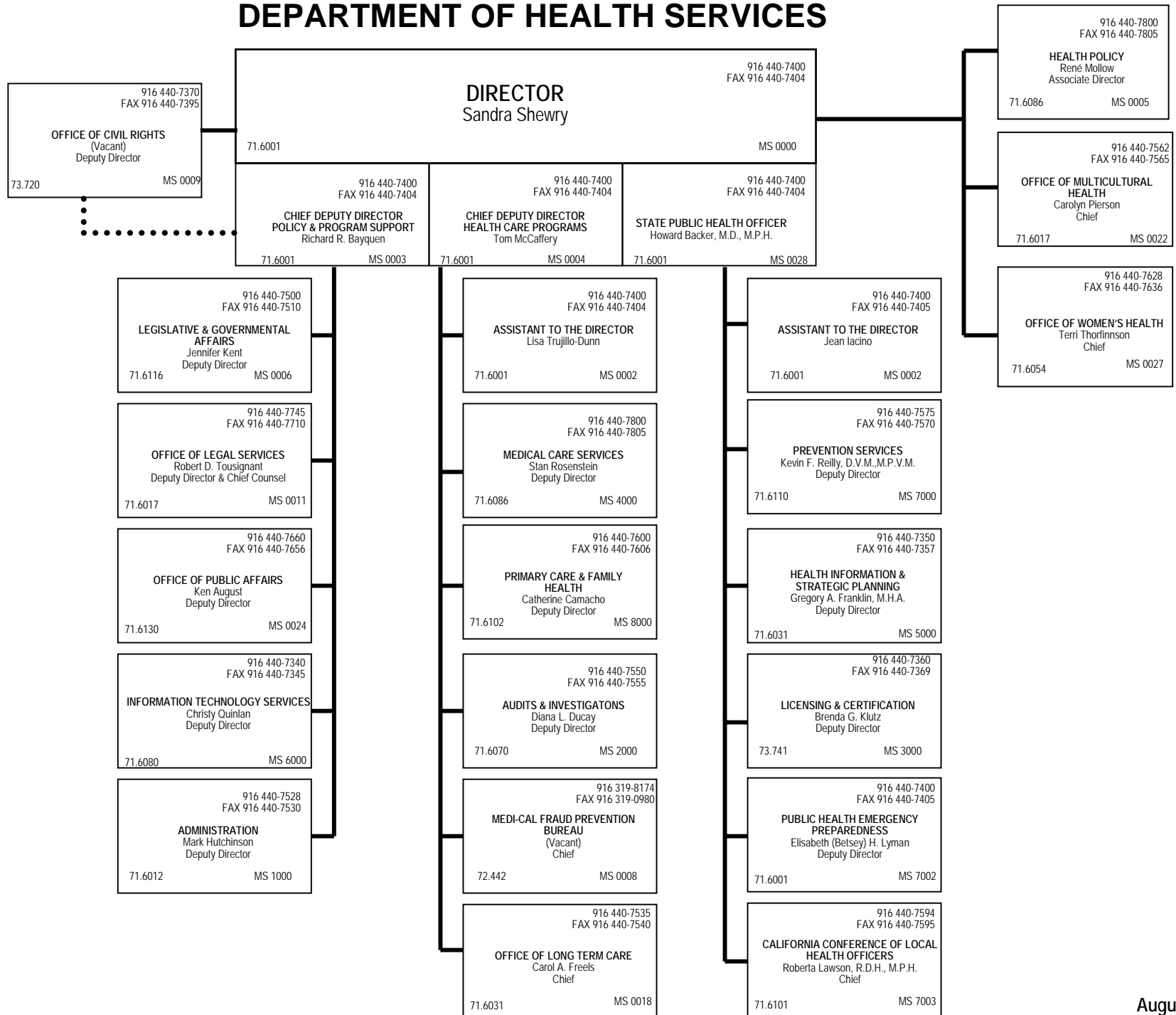
CONTACTS FOR PCRS PROGRAM BY LOCAL HEALTH JURISDICTIONS

County	Contact	Phone Number
Berkeley	Fern Orenstein	(510) 620-3190
Long Beach	Ayo James	(562) 570-4074
Pasadena	Tony Bustamante	(213) 744-3369

The following organization charts are incorporated in this exhibit:

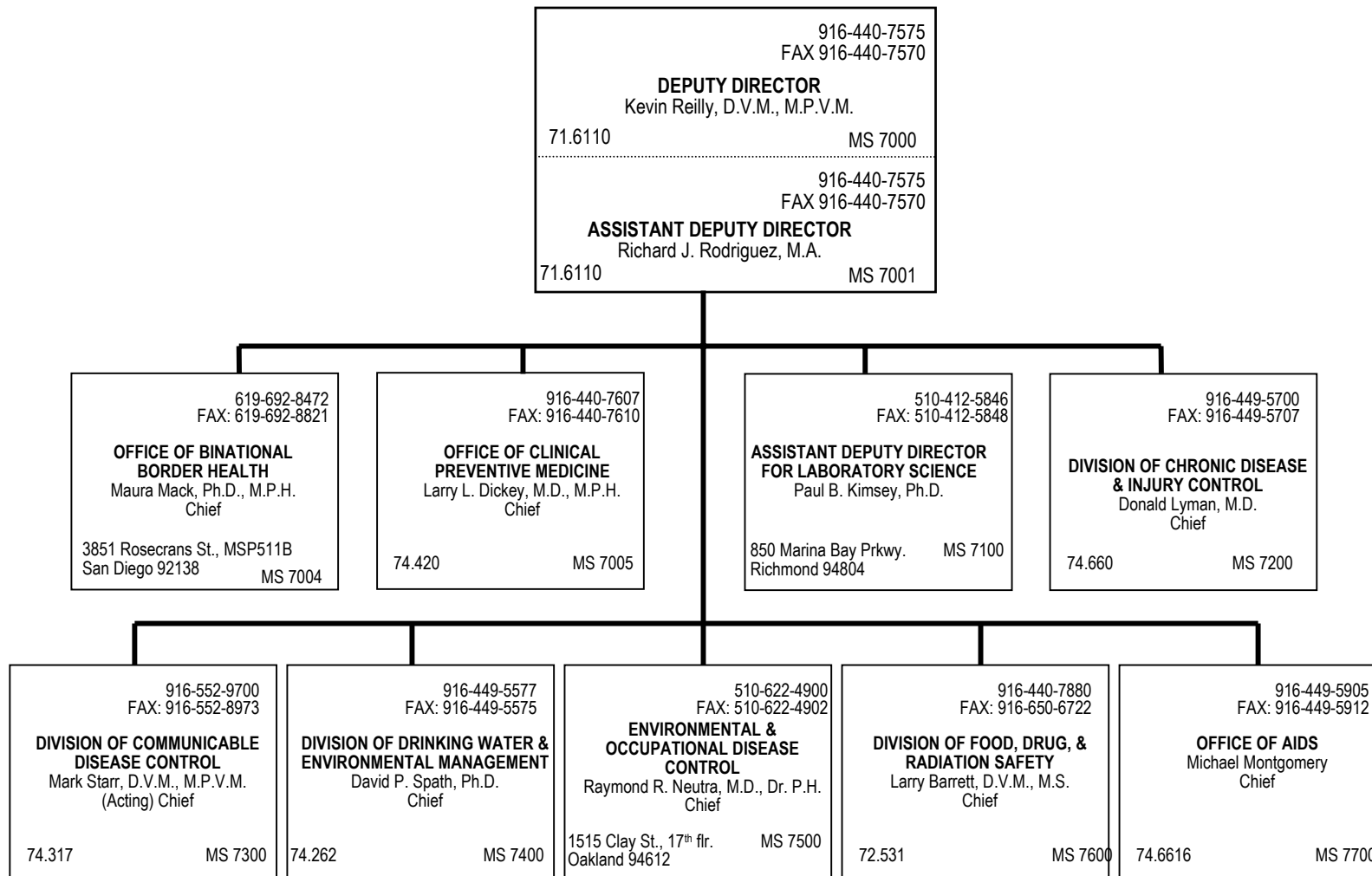
- California Department of Health Services
- Prevention Services Division
- Office of AIDS

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

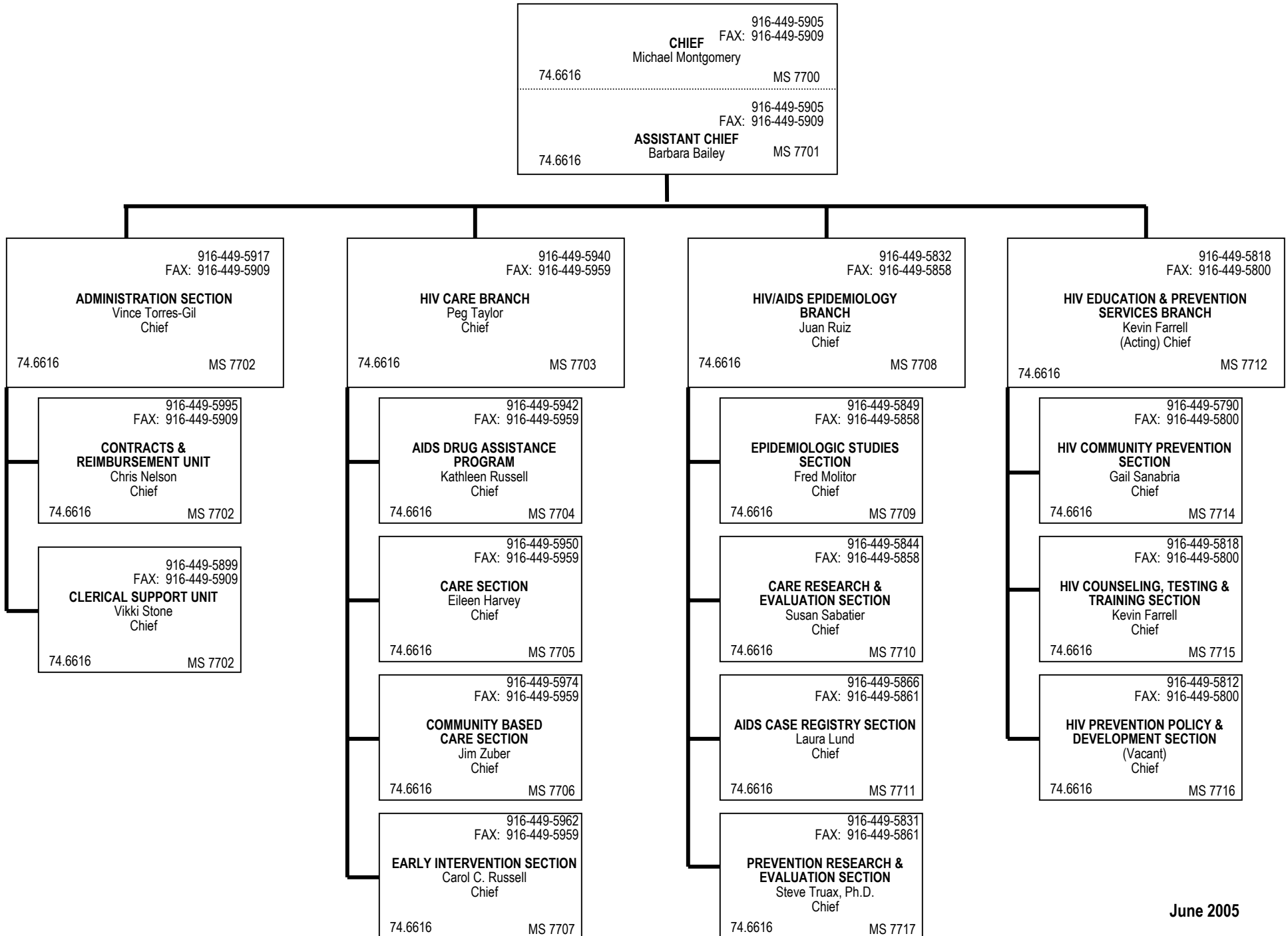


August 2005

CALIFORNIA DEPARTMENT OF HEALTH SERVICES PREVENTION SERVICES



**CALIFORNIA DEPARTMENT OF HEALTH SERVICES
PREVENTION SERVICES
OFFICE OF AIDS**



June 2005

Advisory groups should include representatives from the following:

- health care providers, including federally qualified health centers;
- community-based organizations serving affected populations and AIDS service organizations;
- social service providers, including providers of housing and homeless services;
- mental health and substance abuse providers;
- local public health agencies;
- hospital planning agencies or health care planning agencies;
- affected communities, including people with HIV disease and historically underserved groups and subpopulations;
- non-elected community leaders;
- State government (including the State Medicaid agency and the agency administering the program under part B of the CARE Act;
- grantees under subpart II of part C of the CARE Act;
- grantees under section 2671, or, if none are operating in the area, representatives or organizations with a history of serving children, youth, women, and families living with HIV and operating in the area;
- grantees under other Federal HIV programs, including but not limited to providers of HIV prevention services; and
- representatives of individuals who formerly were Federal, State, or local prisoners, were released from the custody of the penal system during the preceding 3 years, and had HIV disease as of the date on which the individuals were so released.

Key points of entry into medical care include, but are not limited to:

- emergency rooms
- substance abuse treatment programs
- detoxification centers
- adult and juvenile detention facilities
- sexually transmitted disease (STD) clinics
- HIV counseling and testing sites
- mental health programs
- homeless shelters
- health care points of entry specified by the state
- federally qualified health centers
- migrant health centers
- community health centers
- health services for the homeless;
- family planning grantees
- comprehensive hemophilia diagnostic and treatment centers; and
- non-profit and for profit private entities that provide comprehensive primary care services to populations at risk for HIV

Input must be collected from the communities that are reflective of HIV/AIDS infected and affected populations (including historically underserved groups and subpopulations) including, but not limited to the following communities. Input shall be documented in the Service Delivery Plan.

- physically disabled
- visually or hearing impaired
- mentally ill
- developmentally disabled
- gays and lesbians
- homeless
- people with hemophilia
- representatives for the incarcerated
- women
- advocates for new immigrants and undocumented persons
- children, adolescents and youth
- gay men of color
- substance abusers
- ethnic groups including: Latino, African Americans, Asians, Pacific Islanders, Native American
- community members who are HIV+ or have aids and are not currently in care

Fiscal agents are required by the CARE Act legislation to consult with private, local, state and federal agencies. Consultation with the following agencies shall be documented in the Service Delivery Plan; an explanation must be provided if no consultation has been made.

- health care providers
- CBO's serving affected populations and AIDS service organizations
- social service providers including providers of affordable housing and homeless services
- mental health providers
- substance abuse recovery/prevention services providers
- local public health agencies
- hospital planning agencies or health care planning agencies
- non-elected community leaders
- Title III grantees OR organizations with a history of serving children, youth, women and families living with HIV in the area
- federal and State HIV programs in your community, including but not limited to: Prevention Services programs, Early Intervention programs, AIDS Drug Assistance Programs (ADAP) and CMP/Waiver programs, Housing Opportunities for Persons with AIDS. (HOPWA)
- formerly incarcerated individual released from custody during preceding 3 years, with HIV disease as of the release date

HIV Service Delivery Plans provide a “road map” for the development of a system of care and a blueprint for the complex decisions that must be made about planning, developing and delivering comprehensive HIV services in your communities.

Service Delivery Plans will be developed to encompass a three-year period, but may require annual adjustments to address trends in the epidemic, client needs, or the introduction of new program requirements.

**SERVICE DELIVERY
PLAN**

Service Delivery Plan components include:

- Needs Assessment
- Priority Setting and Resource Allocation
- Description of Service Delivery
- Effectiveness Measures

**Needs Assessment
Summary**

The needs assessment process includes the collection of information about the needs of PLWH – both those receiving care and those not in care. The needs assessment is an interconnected component of the other planning tasks; results from the needs assessment will be used in setting priorities for the allocation of funds, developing the service delivery plan, and crafting strategies for meeting the service needs of the populations in your jurisdiction.

You are not required to submit your complete Needs Assessment to the OA, but must instead submit summary information, to include the following:

- Epidemiologic information for your community. Epidemiologic information will describe the current status of the epidemic in your county or region, specifically the prevalence of HIV and AIDS over and among defined populations. The profile should also describe trends in the epidemic.
- Identification of current populations served and the estimated number of individuals served.
- Identification of populations who are out of care and the estimated number of individuals to be served. This includes those people who know their HIV status, but for a variety of reasons are not accessing care, or have chosen

to not access care.

- Resource Inventory
- Assessment of current and anticipated service needs specific to your targeted populations.
- Assessment of current and anticipated service gaps, barriers and unmet needs.
- Discuss unmet, unfounded needs and how they might be addressed through other avenues or programs.

For more information on conducting a Needs Assessment, see the Ryan White Care Act Needs Assessment Guide or the Ryan White CARE Act Title II Manual, Section VIII. (www.hab.hrsa.gov). You can view an online document or order a copy of either or both guides.

**Priority Setting and
Resource Allocation**

CARE Act resources are limited and the need is severe. This heightens the responsibility of Title II programs to use sound information and a rational decision-making process when determining service priorities and the needed funding for each service category. The Ryan White CARE Act Title II Manual (www.hab.hrsa.gov) Section VIII, Chapter 2, Priority Setting and Resource Allocation provides a model and sample charts to help guide your process, though your process may vary from the model.

The description of priority setting and resource allocation processes must include:

- Decision making principles;
- Criteria for priority setting;
- Decision-making method (consensus, score sheets, etc); and
- A chart(s) showing your finalized service priorities and funding allocation decisions.

**Description of Service
Delivery**

The description of service delivery must include the following:

- Using information gathered from the Needs Assessment process, a description of the current and future services you will provide and how those services will reduce or eliminate gaps and barriers to the clients receiving HIV care and treatment in your community.

- Description of how you ensure that contracted services provided are done so in a culturally appropriate manner.
- Description of how cooperation and program coordination among contracted service providers will be established and maintained.
- Identification of the key points of entry into your jurisdiction's HIV medical system, and describe how you will ensure ongoing contact and client referral processes with these identified key points of entry.
- Description of how your program is, or will be, integrated with other activities funded through Office of AIDS' programs. (i.e.: the Early Intervention Program, HOPWA, Community-Based Care/MediCal Waiver Program, ADAP, viral load and resistance testing programs, HIV testing sites, Education and Prevention programs.)
- Description of what steps your jurisdiction is implementing, or proposing to implement to support efforts in integrating "Prevention with Positives" into care settings. Include a description of how you will ensure that prevention for high-risk HIV-infected persons is a part of a standard of care.
- Description of how your program is, or will be, integrated with other Ryan White Title III and IV funded programs in your community and/or in nearby communities.
- Description of how your service continuum will include other state, Federal, local or private service programs and clinics that may have contact with individuals who are unaware of their HIV status and who may become points of entry to HIV medical care in your community.
- A list of your goals and objectives that will support the Office of AIDS priorities, and those of HRSA.

**Effectiveness
Measures**

Describe the method you will use to measure the effectiveness of your highest funded service.

Measuring how well the services you provide meet the needs of your population(s) will tell you how effective your services

are. CARE Act legislation requires this evaluation. Different programs may measure the same service in different ways, depending upon the program's desired outcome.

RESOURCE INVENTORY

A resource inventory describes organizations and individuals, both HIV- and non-HIV-specific, providing the full spectrum of services accessible to clients in your service area. The goal of the resource inventory is to develop a comprehensive picture of services, regardless of funding source.

The inventory should include services such as HIV prevention, substance abuse prevention and treatment, and early intervention services and outreach. You may use an existing format or create your own form as long as it contains the following required fields. Additional information on developing resource inventories is available in the Ryan White CARE Act Needs Assessment Guide (www.hab.hrsa.gov), Section VIII, Chapter 1.

At a minimum, resource inventories must include the following information:

- Potential and current provider's name, address, phone number and contact person.
- Geographic location and project area.
- Program focus, including whether or not focus is specifically HIV care.
- Categories or types of services provided.
- PLWH caseload capacity. (How many they can serve)
- Targeted populations(s).
- HIV funding sources (CARE Act, other Office of AIDS funded programs other public, private).
- Reported barriers to care.

GOALS AND OBJECTIVES

Goals and objectives are tools that help the state, fiscal agents and advisory members meet the intent of the Ryan White CARE Act.

HRSA created goals and objectives for their programs, including those funded under the CARE Act. HRSA required that the OA, as Title II Grantee, develop a Comprehensive Plan that includes goals and objectives that support HRSA's

goals. Additionally, the OA is required to ensure that all programs funded through Title II of the CARE Act coordinate their activities to meet the overarching goals of the RWCA as defined and guided by HRSA.

Therefore, fiscal agents and planning groups will develop local HIV Service Delivery Plans and include goals and objectives specific to the needs of the community, while supporting of the goals and objectives of OA and HRSA.

**OA's Guiding
Principles from the
Comprehensive Plan**

The OA, along with input and guidance from a group of consumer advisors and program administrators, developed the following Mission Statement to help guide and focus our efforts:

All people with HIV must have full access to HIV care, treatment, support and prevention for positives services that improve health outcomes, eliminate health disparities, enhance quality of life, and stop HIV transmission.

**CARE Services
Program Goals**

These five goals were identified as mission-critical to the CARE Section.

1. Enhance the quality of care by providing culturally competent and respectful services at all levels of care, including in regard to ethnicity, gender, sexuality, age, primary language, mental health condition, substance use, housing status, and incarceration history.
2. Expand integration of HIV prevention services in care settings to help halt the spread of HIV.
3. Ensure comprehensive systems for bringing people with HIV into care, including systems to link them to care at the time of HIV testing.
4. Ensure effective linkage, coordination and integration of HIV-specific services and resources on a local and statewide basis
5. Encourage and support the inclusion of local prevention planning groups in the care planning process.

The OA will research and disseminate best practices

information using your successful goals and objectives. Additionally, at the end of the contract year, we report your program's progress in meeting these goals to HRSA.

Fiscal agents develop one goal and objective to support each of the five goals listed above. Goals and objectives cover the three-year period from 4-1-2004 – 3-31-2007. The OA recognizes that programs may have additional goals they wish to meet; however, the OA goals must be the primary focus of the Care Services Programs. A program's approach to addressing these goals will be highly individual and tailored to meet the unique needs of their identified targeted populations. Fiscal agents should address the needs of each targeted population group. Progress in meeting these goals is reported in the mid-year and year-end report.

What we do:	<ul style="list-style-type: none"> • Provide Ryan White Care Act funds to county health departments and community-based organizations for the provision of care and treatment services to those infected with HIV/AIDS and their families. • Assist with development of, and/or enhancement of, access to a comprehensive continuum of high quality, community-based medical care and support services. • Reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve quality of life for those affected by HIV/AIDS. • Fill gaps in care not covered by other resources by acting as “payer of last resort.”
Who we serve:	<p>Funds are made available to all 58 counties in California to provide access to primary medical care and a range of services to individuals and families with HIV disease. Target populations include:</p> <ul style="list-style-type: none"> • Racial and ethnic minorities who know they have HIV/AIDS but are not receiving specialized primary medical care. • Each county or multiple-county service group identifies specific target populations.
Who is eligible:	<p>Individuals infected with HIV and those who have clinically defined AIDS, and their families. Providers may optionally define eligibility for certain services more precisely, but may not broaden the definition of who is eligible for services.</p>
Eligible beneficiaries:	<p>Individuals who are underserved by healthcare and prevention systems. Users of these services include people with no source of healthcare and support systems whose care needs are not being met.</p>
What we’ve done:	<ul style="list-style-type: none"> • Receive input from communities that are reflective of HIV/AIDS infected and affected populations (including historically underserved groups and subpopulations) in each jurisdiction. • Consult with private, local, state and federal agencies in developing HIV/AIDS service delivery plans and to avoid duplication of services. • Provide technical assistance to counties and non-profit organizations.
Helpful resources:	<p>California Department of Health Services Office of AIDS Care Services Program www.dhs.ca.gov/aids</p> <p>U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) 1-888-275-4772 www.ask.hrsa.gov</p>

14 Years of the CARE Act (1990-2004)

- 1990** The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is passed. There are over 150,000 reported AIDS cases in the U.S.
- 1991** The first CARE Act funds are awarded for Fiscal Year 1991 and include 16 Title I Eligible Metropolitan Areas, State Title II grants, Title III early intervention projects, and Special Projects of National Significance (SPNS).
- 1992** Two more EMAs are added to the list of eligible Title I grantees.
- 1993** The AIDS definition is revised by CDC and 7 more EMAs become eligible as Title I EMAs, increasing the total to 25.
- 1994** HRSA releases its program advisory outlining specific steps for implementing Public Health Service (PHS) recommendations for offering AZT (ZDV) to pregnant women with HIV.
- Title IV evolves from Pediatric AIDS Demonstration Grants, which started in 1988, to funding under the CARE Act.
- 1997** The HIV/AIDS Dental Reimbursement Program started as AIDS dental reimbursements in 1994, are funded under the CARE Act for the first time. AETCs are funded under the CARE Act for the first time.
- 1998** HRSA brings all CARE Act programs under the new HIV/AIDS Bureau, consolidating activities under the same administrative structure for the first time.
- 1999** Three national AETC centers are funded: National Resource Center; National Evaluation Center; and National Minority AETC. Targeted Provider Education Demonstration (TPED) grants are awarded to train non-clinicians to support HIV/AIDS education and training for health and support service providers working in racial and ethnic minority communities highly impacted by HIV/AIDS.
- 2000** The CARE Act Amendments of 2000 reauthorize the CARE Act.

2001 HRSA's HIV/AIDS Bureau implements 2000 Amendments through programs like the new AIDS Drug Assistance Programs (ADAP) funding for areas with severe need and new Title II emerging community grants.

2002 International AIDS Education and Training Center (AETC) funded, creating a new link between U.S. and international HIV/AIDS care provider training.

2003 HRSA's Global HIV/AIDS Program started.

Clinical Guide on Supportive and Palliative Care for People with HIV/AIDS produced.

2004 Institute of Medicine report, Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White, recommends U.S. government subsidization of HIV/AIDS care for all people living with HIV with incomes below 250% of the Federal poverty level.

Institute of Medicine report, Measuring What Matters, recommends continued use of AIDS data for allocating CARE Act dollars until HIV surveillance systems have further evolved.

Before the CARE Act: 1985-90

Pre Titles

Title I The AIDS/HIV Service Demonstration Program—the forerunner of Title I—begins in 1985, with funds provided to 4 urban areas. Administered by HRSA, projects are charged with creating model service delivery for persons living with HIV/AIDS in areas hit hardest by the epidemic.

Title II HIV Planning Grants are awarded in 1988 to 11 states and 10 cities to plan for HIV/AIDS systems of care, creating a foundation for statewide planning and care systems later established under Title II funds.

The Home and Community Based Care State grant program is funded in 1989 at \$20 million program. Later included in the CARE Act Title II state grants, these funds were the first involvement in HIV/AIDS care and treatment for many states.

ADAP Funds are awarded to States in 1987, via letters to the governors, to pay for AZT—the first antiretroviral drug approved by FDA. This "one-time" appropriation of \$30 million later becomes the AIDS Drug Assistance Program (ADAP), the state-administered program authorized by the CARE Act of 1990 that pays for HIV treatments for low income under-served individuals.

Title III Three community health centers are funded at \$150,000 each under a HRSA/CDC initiative to provide HIV counseling and testing within a primary care setting in order to enhance access to care to those testing HIV-positive. The effort quickly expands to \$11 million for 7 grants in 1989.

Title IV Pediatric AIDS Service Demonstration Grants—later to become Title IV—are funded in 1988 and are administered by HRSA's Maternal and Child Health Bureau.

The 1610b "bricks and mortar" program funds construction of HIV/AIDS skilled nursing facilities in the 1980s.

Part F AIDS Education and Training Centers (AETCs) begin operations in 1988 to educate providers on HIV/AIDS care.

**The AIDS
Education and
Training Centers
(AETC)**

The AETCs Program is a network of 11 regional centers (and more than 70 associated sites) that train health care providers to treat persons with HIV/AIDS. The AETCs serve all 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, and the six U.S. Pacific Jurisdictions. The AETCs Program has trained over 700,000 health care providers. The program goal is to increase the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage individuals with HIV infection and to help prevent high risk behaviors that lead to HIV transmission.

Provider Training

- Training targets health care providers who serve minority populations, the homeless, rural communities, incarcerated persons, and Ryan White CARE Act-funded sites.
- The AETCs focus on training physicians, physician assistants, nurses, nurse practitioners, dentists, pharmacists;
- Training activities are based upon assessed local needs.
- Emphasis is placed on interactive, hands-on training and clinical consultation to assist providers with complex issues related to the management of highly active antiretroviral therapy.
- The AETCs collaborate with Ryan White CARE Act-funded organizations, area health education centers, community-based HIV/AIDS organizations, and medical and health professional organizations.
- Clinicians trained by AETCs have been shown to be more competent with regard to HIV issues and more willing to treat persons living with HIV than other primary care providers.

National Centers

The following Centers support and complement the regional AETCs' educational and training activities:

National Minority AIDS Education and Training Center (NMAETC) builds capacity for HIV care and training among minority health care professionals and health care professionals serving communities of color.

AETC National Resource Center (NRC) disseminates training resources and the latest HIV clinical information across the family of AETCs grantees via the Internet and other media. It also provides a mechanism for communication of best practices and dissemination of AETCs program tools across the AETCs program.

National HIV/AIDS Clinicians' Consultation Center (NCCC) provides health care providers with timely and appropriate responses to clinical questions related to treatment of persons with HIV infection (WarmLine) and/or possible health care worker exposure to HIV and other blood-borne pathogens (PEPline).

**The Pacific AIDS
Education and
Training Center
(PAETC)**

National Evaluation Center is responsible for program evaluation activities, including assessing the effectiveness of AETCs grantees education, training, and consultation activities.

The Pacific AIDS Education and Training Center (PAETC) provides AIDS-related training, education and information services to health care providers. PAETC has 15 local sites in California, Arizona, Hawaii and Nevada that provide services in their local region. PAETC is an affiliate of the University of California, San Francisco AIDS Research Institute, and is funded by the [Health Resources and Services Administration](#) under the Ryan White CARE Act.

Mission

- To provide health care professionals with the knowledge and skills necessary to care for HIV-infected patients in underserved and vulnerable populations
- To increase the numbers of trained health care professionals working with HIV-infected patients
- To respond to the needs of high-risk populations and the changing face of the epidemic

Target Audience

PAETC offers education and training programs specifically designed for

- Physicians
- Nurses
- Physician Assistants
- Nurse Practitioners
- Dentists
- Dental Hygienists
- Pharmacists
- Other health care professionals

Clinical Training Programs

PAETC offers clinical training programs for busy practitioners with the most current information on the management of HIV-infected patients and interventions to prevent high-risk behavior. Training is adapted to high, medium, or low volume providers.

Formats include:

- Lectures and didactic seminars
- Workshops, seminars and hands-on clinical experience
- Intensive clinical rotations, preceptorships and mini-residencies
- Clinical consultation on all aspects of managing patient care
- Technical assistance in quality of HIV care

Faculty are recognized clinical care experts and include physicians, nurse practitioners, nurses, pharmacists and dentists.

Call the [local AETC](#) in your region for details about training opportunities. Continuing education credit is available for many programs.

Information Dissemination

PAETC provides resources to assist clinicians with difficult care decisions. Resources include treatment guidelines, slides, videos, and landmark journal articles. Teaching aides, such as curricula and slide sets, on many clinical care topics are also available.

Special Areas of Interest

PAETC has projects to build and expand provider capacity in the following settings:

- Correctional institutions
- U.S. - Mexico border
- Community-based organizations serving at-risk minorities
- Collaborations to address STD, HIV and TB provider training together

Contact the PAETC Central Office for additional information on these and other areas of special interest.

National Network

PAETC is part of a nationwide network of 11 regional AETCs, which collectively serve the United States, Puerto Rico, the Virgin Islands and the 6 U.S. affiliated Pacific Island jurisdictions. You may download the new national map of AETCs from www.aidsetc.org/pdf/about/aetcnrc_map.pdf.

PAETC Contacts

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University of California, San Francisco

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San Francisco, CA 94105-3444

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Fax: 415-597-9386

Web Site: www.ucsf.edu/paetc

Newsletter: [NewsBrief](#)

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Phone: 415-597-9186

Performance Sites

Arizona

Arizona AIDS ETC

Address: 1501 North Campbell Avenue
P.O. Box 24-5039
Tucson, AZ 85724

Phone: 520-626-6469

Fax: 520-626-6134

LPS Profile: www.ucsf.edu/paetc/resources#lps

Contacts: Robert Castrillo – Program Director
E-Mail: robertc@u.arizona.edu

Carol Q. Galper, EdD – Principal Investigator
E-Mail: cgalper@u.arizona.edu

California

San Joaquin Valley AETC

San Joaquin Valley Health Consortium

Address: 2109 W. Bullard Avenue, Suite 149
Fresno, CA 93711
Phone: 559-446-2323, Extension 4
Fax: 559-446-2327
Web Site: www.sjvhc.org/programs/sjvaetc.htm
LPS Profile: www.ucsf.edu/paetc/resources#lps
Contacts: Mary C. Wallace – Director
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Andres Alba – Program Manager
E-Mail: andya@sjvhc.org

USC AETC

Keck School of Medicine University of Southern California

Address: 1420 San Pablo Street, PMB B205
Los Angeles, CA 90089-9049
Phone: 323-442-1846
Fax: 323-442-1843
Web Site: www.paetc.com
www.hivtools.com
LPS Profile: www.ucsf.edu/paetc/resources#lps
Contacts: Jerry D. Gates, PhD – Director
E-Mail: jdgates@hsc.usc.edu
Sue A. Lemme, MA – Co-Director
E-Mail: lemme@hsc.usc.edu

UCLA AETC

Center for Health Promotion and Disease Prevention
University of California, Los Angeles

Address: 10880 Wilshire Boulevard, Suite 1800
Los Angeles, CA 90024-4142
Phone: 310-794-8276
Fax: 310-794-6097
LPS Profile: www.ucsf.edu/paetc/resources#lps

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Drew University AETC

Charles R. Drew University of Medicine and Science

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Nanette Marchand – Program Administrator
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East Bay AIDS ETC

Alameda County Medical Center HIV Services

Address: 470 27th Street
Oakland, CA 97612
Phone: 510-271-4513
Fax: 510-271-4366
LPS Profile: www.ucsf.edu/paetc/resources#lps

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University of California Irvine AIDS ETC

University of California, Irvine

Address: 101 City Drive S. Route 81, Building 53
Orange, CA 92868
Phone: 714-456-5134
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LPS Profile: www.ucsf.edu/paetc/resources#lps

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University of California Davis AIDS ETC

University of California, Davis

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University of California San Diego AIDS ETC

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San Jose AETC

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Health Education and Training Center

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Hawaii AETC

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Nevada

Las Vegas AIDS ETC

Southern Nevada AHEC

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Nevada AIDS ETC Reno AIDS ETC
School of Medicine University of Nevada

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Reno, NV 89557
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Fax: 775-784-4544
Web Site: www.snahec.org
LPS Profile: www.ucsf.edu/paetc/resources#lps
Contacts: Patricia Charles, DrPH – Site Director
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AACTG (Adult AIDS Clinical Trials Group)

Largest HIV clinical trials organization in the world, which plays major role in setting standards of care for HIV infection and opportunistic diseases related to HIV/AIDS in the United States and the developed world. The AACTG is composed of, and directed by, leading clinical scientists in HIV/AIDS therapeutic research.

ACTG (AIDS Clinical Trials Group)

A network of medical centers around the country in which federally funded clinical trials are conducted to test the safety and efficacy of experimental treatments for AIDS and HIV infection. These studies are funded by the NIH National Institute of Allergy and Infectious Diseases (NIAID).

ADAP (AIDS Drug Assistance Program)

Administered by States and authorized under Title II of the CARE Act, provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured CARE Act clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.

Administrative or Fiscal Agent

Entity that functions to assist the grantee, consortium, or other planning body in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing Requests for Proposals [RFPs], monitoring contracts).

AETC (AIDS Education and Training Center)

Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the CARE Act and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).

AHRQ (Agency for Healthcare Research and Quality)

Federal agency within HHS that supports research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.

AIDS (Acquired Immunodeficiency Syndrome)

A disease caused by the human immunodeficiency virus.

Antiretroviral

A substance that fights against a retrovirus, such as HIV. (See Retrovirus)

ASO (AIDS service organization)

An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

Capacity

Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system and reduce disparities in care among underserved PLWH in the EMA.

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act)

Federal legislation created to address the unmet health care and service needs of people living with HIV Disease (PLWH) disease and their families. It was enacted in 1990 and reauthorized in 1996 and 2000.

CADR (CARE Act Data Report)

A provider-based report generating aggregate client, provider, and service data for all CARE Act programs. Reports information on all clients who receive at least one service during the reporting period. Replaces the Annual Administrative Report (AAR) used for Title I and Title II as well as separate Title III and Title IV data reports.

CBO (community-based organization)

An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

CDC (Centers for Disease Control and Prevention)

Federal agency within HHS that administers disease prevention programs including HIV/AIDS prevention.

CD4 or CD4+ Cells

Also known as "helper" T-cells, these cells are responsible for coordinating much of the immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.

CD4 Cell Count

The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. (The normal range for infants is considerably higher and slowly declines to adult values by age 6 years.) CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm³. If the count is lower, testing every 3 months is advised. (In children with HIV infection, CD4 values should be checked every 3 months.) A CD4 count of 200 or less is an AIDS-defining condition.

Chief Elected Official (CEO)

The official recipient of Title I or Title II CARE Act funds. For Title I, this is usually a city mayor, county executive, or chair of the county board of supervisors. For Title II, this is usually the governor. The CEO is ultimately responsible for administering all aspects of their title's CARE Act funds and ensuring that all legal requirements are met.

CMS (Centers for Medicare and Medicaid Services)

Federal agency within HHS that administers the Medicaid, Medicare, State Child Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

Co-morbidity

A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Community Forum or Public Meeting

A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Comprehensive Planning

The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.

Community Health Centers

Federally-funded by HRSA's Bureau of Primary Health Care, centers provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.

Consortium/HIV Care Consortium

A regional or statewide planning entity established by many State grantees under Title II of the CARE Act to plan and sometimes administer Title II services. An association of health care and support service agencies serving PLWH under Title II of the CARE Act.

Continuous Quality Improvement

An ongoing process that involves organization members in monitoring and evaluating programs to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care by identifying opportunities for improvement.

Continuum of Care

An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH.

CPCRA (Community Programs for Clinical Research on AIDS)

Community-based clinical trials network that obtains evidence to guide clinicians and PLWH on the most appropriate use of available HIV therapies.

Cultural Competence

The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

DCBP (Division of Community Based Programs)

The division within HRSA's HIV/AIDS Bureau that is responsible for administering Title III, Title IV, and the HIV/AIDS Dental Reimbursement Program.

DSS (Division of Service Systems)

The division within HRSA's HIV/AIDS Bureau that administers Title I and Title II of the CARE Act.

DTTA (Division of Training and Technical Assistance)

The division within HRSA's HIV/AIDS Bureau that administers the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.

Early Intervention Services (EIS)

Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Titles I and II of the CARE Act, includes outreach, counseling and testing, information and referral services. Under Title III of the CARE Act, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

Eligible Metropolitan Area (EMA)

Geographic areas highly-impacted by HIV/AIDS that are eligible to receive Title I CARE Act funds.

EIA (Enzyme-Linked Immunosorbent Assay)

The most common test used to detect the presence of HIV antibodies in the blood, which indicate ongoing HIV infection. A positive ELISA test result must be confirmed by another test called a Western Blot.

Epidemic

A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Epidemiologic Profile

A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

Epidemiology

The branch of medical science that studies the incidence, distribution, and control of disease in a population.

Exposure Category

In describing HIV/AIDS cases, same as transmission categories; how an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.

Family Centered Care: A model in which systems of care under Ryan White Title IV are designed to address the needs of PLWH and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.

FDA (Food and Drug Administration)

Federal agency within HHS responsible for ensuring the safety and effectiveness of drugs, biologics, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood banking industry to safeguard the nation's blood supply.

Financial Status Report (FSR - Form 269)

A report that is required to be submitted within 90 days after the end of the budget period that serves as documentation of the financial status of grants according to the official accounting records of the grantee organization.

Formula Grant Application

The application used by EMAs and States each year to request an amount of CARE Act funding which is determined by a formula based on the number of reported AIDS cases in their location and other factors. The application responds to guidance from DSS on program requirements and expectations.

Genotypic Assay

A test that analyzes a sample of the HIV virus from the patient's blood to identify actual mutations in the virus that are associated with resistance to specific drugs.

Grantee

The recipient of CARE Act funds responsible for administering the award.

HAART (Highly Active Antiretroviral Therapy)

HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels.

Health Care for the Homeless Health Center

A grantee funded under section 330(h) of the Public Health Service Act to provide primary health and related services to homeless individuals.

Health Insurance Continuity Program (HICP)

A program primarily under Title II of the CARE Act that makes premium payments, co-payments, deductibles, and/or risk pool payments on behalf of a client to purchase/maintain health insurance coverage.

High-Risk Insurance Pool

A State health insurance program that provides coverage for individuals who are denied coverage due to a pre-existing condition or who have health conditions that would normally prevent them from purchasing coverage in the private market.

HIV/AIDS Bureau (HAB)

The bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White CARE Act.

HIV/AIDS Dental Reimbursement Program

The program within the HRSA HIV/AIDS Bureau's Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to PLWH.

HIV Disease

Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

Home and Community Based Care

A category of eligible services that States may fund under Title II of the CARE Act.

HOPWA (Housing Opportunities for People With AIDS)

A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for PLWH and their families.

HRSA (Health Resources and Services Administration)

The agency of the U.S. Department of Health and Human Services that administers various primary care programs for the medically underserved, including the Ryan White CARE Act.

HUD (U.S. Department of Housing and Urban Development)

The Federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for People with AIDS (HOPWA).

IDU (Injection Drug User)

IGA (Intergovernmental Agreement)

A written agreement between a governmental agency and an outside agency that provides HIV services.

Incidence

The number of new cases of a disease that occur during a specified time period.

Incidence Rate

The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 persons. AIDS incidence rates are often expressed this way.

Lead Agency: The agency within a Title II consortium that is responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency)

Medicaid Spend-down

A process whereby an individual who meets the Medicaid medical eligibility criteria, but has income that exceeds the financial eligibility ceiling, may "spend down" to eligibility level. The individual accomplishes spend-down by deducting accrued medically related expenses from countable income. Most State Medicaid programs offer an optional category of eligibility, the "medically needy" eligibility category, for these individuals.

Migrant Health Centers

Federally-funded by HRSA's Bureau of Primary Health Care, centers provide a broad array of culturally and linguistically competent medical and support services to migrant and seasonal farmworkers (MSFW) and their families.

MAI (Minority AIDS Initiative)

A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. Enacted to address the disproportionate impact of the disease in such communities. Formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

Multiply Diagnosed

A person having multiple morbidities (e.g., substance abuse and HIV infection) (see co-morbidity).

Needs Assessment

A process of collecting information about the needs of PLWH (both those receiving care and those not in care), identifying current resources (CARE Act and other) available to meet those needs, and determining what gaps in care exist.

NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitor, called " non-nuke ")

A class of antiretroviral agents (e.g., delavirdine, nevirapine, efavirenz) that stops HIV production by binding directly onto an enzyme (reverse transcriptase) in a CD4+ cell and preventing the conversion of HIV's RNA to DNA.

Nucleoside Analog (Nucleoside Analog Reverse Transcriptase Inhibitor, NRTI, called "nuke")

The first effective class of antiviral drugs (e.g., AZT or ZDV, ddI, ddC, d4T, ABC). NRTIs act by incorporating themselves into the HIV DNA, thereby stopping the building process. The resulting HIV DNA is incomplete and unable to create new virus.

OMB (Office of Management and Budget)

The office within the executive branch of the Federal government that prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Opportunistic Infection (OI) or Opportunistic Condition

An infection or cancer that occurs in persons with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus (CMV) are all examples of opportunistic infections.

OSE (Office of Science and Epidemiology)

The office within HRSA's HIV/AIDS Bureau that administers the SPNS Program, HIV/AIDS evaluation studies, and the Cross-Title Data Report Form.

PACTG (Pediatric AIDS Clinical Trials Group)

Body that evaluates treatments for HIV-infected children and adolescents and develops new approaches for the interruption of mother-to-infant transmission.

Part F

The part of the CARE Act that includes the AETC Program, the SPNS Program, and the HIV/AIDS Dental Reimbursement Program.

PCR (Polymerase Chain Reaction)

A laboratory process that selects a DNA segment from a mixture of DNA chains and rapidly replicates it to create a sample of a piece of DNA. For HIV, this is called RT-PCR, which is a laboratory technique that can detect and quantify the amount of HIV (viral load) in a person's blood or lymph nodes. PCR is also used for the diagnosis of HIV infection in exposed infants.

Phenotypic Assay

A procedure whereby sample DNA of a patient's HIV is tested against various antiretroviral drugs to see if the virus is susceptible or resistant to these drug(s).

PHS (Public Health Service)

An administrative entity of the U.S. Department of Health and Human Services.

Planning Council

A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish priorities for the use of Title I CARE Act funds.

Planning Process

Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

PLWH (People Living with HIV Disease)

Prevalence

The total number of persons in a defined population living with a specific disease or condition at a given time (compared to incidence, which is the number of new cases).

Prevalence Rate

The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Priority Setting

The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Prophylaxis

Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has previously been brought under control (secondary prophylaxis).

Protease

An enzyme that triggers the breakdown of proteins. HIV's protease enzyme breaks apart long strands of viral protein into separate proteins constituting the viral core and the enzymes it contains. HIV protease acts as new virus particles are budding off a cell membrane.

Protease Inhibitor

A drug that binds to and blocks HIV protease from working, thus preventing the production of new functional viral particles.

Quality

The degree to which a health or social service meets or exceeds established professional standards and user expectations.

QA (Quality Assurance)

The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

QI (Quality Improvement)

Also called Continuous Quality Improvement (CQI). An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery. CQI seeks to prevent problems and to maximize the quality of care.

Reflectiveness

The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

Reliability

The consistency of a measure or question in obtaining very similar or identical results when used repeatedly; for example, if you repeated a blood test three times on the same blood sample, it would be reliable if it generated the same results each time.

Representative

Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

RFP (Request for Proposals)

An open and competitive process for selecting providers of services (sometimes called RFA or Request for Application).

Resource Allocation

The Title I planning council responsibility to assign CARE Act amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Retrovirus

A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.

Reverse Transcriptase

A uniquely viral enzyme that constructs DNA from an RNA template, which is an essential step in the life cycle of a retrovirus such as HIV. The RNA-based genes of HIV and other retroviruses must be converted to DNA if they are to integrate into the cellular genome. (See Retrovirus.)

Risk Factor or Risk Behavior

Behavior or other factor that places a person at risk for disease; for HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.

RT-PCR (Reverse Transcriptase Polymerase Chain Reaction)

A laboratory technique that can detect and quantify the amount of HIV (viral load) in a person's blood or lymph nodes.

Salvage Therapy:

A treatment effort for people who are not responding to, or cannot tolerate the preferred, recommended treatments for a particular condition. In the context of HIV infection, drug treatments that are used or studied in individuals who have failed one or more HIV drug regimens. In this case, failed refers to the inability to achieve or sustain low viral load levels.

SAMHSA (Substance Abuse and Mental Health Services Administration)

Federal agency within HHS that administers programs in substance abuse and mental health.

SCSN (Statewide Coordinated Statement of Need)

A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN process is convened by the Title II grantee, with equal responsibility and input by all programs.

Section 340B Drug Discount Program

A program administered by the HRSA's Bureau of Primary Care, Office of Pharmacy Affairs established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain grantees of Federal agencies.

Seroconversion

The development of detectable antibodies to HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies to HIV appear in the blood, a person will test positive in the standard ELISA test for HIV.

Seroprevalence

The number of persons in a defined population who test HIV-positive based on HIV testing of blood specimens. (Seroprevalence is often presented either as a percent of the total specimens tested or as a rate per 100,000 persons tested.)

Service Gaps

All the service needs of all PLWH except for the need for primary health care for individuals who know

their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care ("in care").

SPNS (Special Projects of National Significance)

A health services demonstration, research, and evaluation program funded under Part F of the CARE Act to identify innovative models of HIV care. SPNS projects are awarded competitively.

STD (Sexually Transmitted Disease)

Surveillance

An ongoing, systematic process of collecting, analyzing and using data on specific health conditions and diseases (e.g., Centers for Disease Control and Prevention surveillance system for AIDS cases).

Surveillance Report

A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.

TA (Technical Assistance)

The delivery of practical program and technical support to the CARE Act community. TA is to assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating CARE Act-supported planning and primary care service delivery systems.

Target Population

A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

Title I

The part of the CARE Act that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV/AIDS epidemic.

Title II

The part of the CARE Act that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWH and their families.

Title III

The part of the CARE Act that supports outpatient primary medical care and early intervention services to PLWH through grants to public and private non-profit organizations. Title III also funds capacity development and planning grants to prepare programs to provide EIS services.

Title IV

The part of the CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

Transmission Category

A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include, for example, men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.

Unmet Need

The unmet need for primary health services among individuals who know their HIV status but are not receiving primary health care.

Viral Load:

In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.

Viremia

The presence of virus in blood or blood plasma. Plasma viremia is a quantitative measurement of HIV levels similar to viral load but is accomplished by seeing how much of a patient's plasma is required to spark an HIV infection in a laboratory cell culture.

Western Blot

A test for detecting the specific antibodies to HIV in a person's blood. It is commonly used to verify positive EIA tests. A Western Blot test is more reliable than the EIA, but it is more difficult and more costly to perform. All positive HIV antibody tests should be confirmed with a Western Blot test.

Wild Type Virus

HIV that has not been exposed to antiviral drugs and therefore has not accumulated mutations conferring drug resistance.

A	
AETC	The AIDS Education and Training Centers
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
B	
C	
CA	Contract Amendment
CADR	CARE Act Data Report
CARE Act	Ryan White Comprehensive AIDS Resource Emergency Act
CBO	Community-Based Organization
CCR	California Code of Regulations
CDC	Center for Disease Control and Prevention
CEO	Chief Elected Official
CFR	Code of Federal Regulations
CHPG	California HIV Planning Group
CMP	Case Management Program
CMS	Centers for Medicare and Medicaid Services
CSP	Care Services Program
D	
DHHS	Department of Health and Human Services
DHS	Department of Health Services
DSS	Division of Service Systems
E	
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
F	
FA	Fiscal Agent
FSR	Financial Status REport
G	
H	
HAB	HIV/AIDS Bureau
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons With AIDS
HRSA	Health Resources and Services Administration
I	
J	
K	

L	
M	
MOU	Memo of Understanding
N	
O	
OA	
P	
PCRS	Partner Counseling and Referral Service
PLWA	People Living With AIDS
PLWH	People Living With HIV Disease
PPD	Purified Protein Derivative (Tuberculin Skin Test)
Q	
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
R	
RWCA	Ryan White CARE Act
S	
SPNS	Special Projects of National Significance
T	
U	
V	
W	
WICY	Women, Infants, Children and Youth
X	
Y	
Z	

Office of AIDS Care Services Program (CSP) Administrative Manual	Exhibit 26 Subject Index/Cross Reference
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See attached.

Exhibit 26

Subject Index/Cross Reference

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Exhibit 26

Subject Index/Cross Reference

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Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Budget Overview	J				13			
Budget Overview Sample					14			
Budget Revisions			3	3.8				
Budget Summary - Fiscal Agent					15			97-09
Buildings/Improvements	A	5.D.19						
Cancellation/Termination	E	3						
CARE Act Contacts							XI	
CARE Act Legislation			Exhibit 1				I	
Care Services Program (New Model)			3	3.1				02-07 02-03
CAREWare			3	3.20				01-11
Cash Payments to Clients	A	5.D.18	4	4.3				
Certification Clauses (CCC 304)	C (GTC 304)	11						
Charges for Services	A	D.29	2	2.9				
Chief Elected Official Guide							IX	
Child Care for Eligible Individuals						2.2		
Child Support Compliance Act	C (GTC 304)	16						
Client Eligibility	A	5.D.13	2	2.8		1		
Clients Rights and Responsibilities			5	5.4				
Clinical Trials for Eligible Individuals						2.3		
Clothing						2.18		
Compensation	C (GTC 304)	13						

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Complimentary Therapies for Eligible Individuals						2.4		
Conditions of Award/Ryan White CARE Act, Title II Funds	A	5.D						97-09
Confidentiality of Information	D(F) K	13 9	5	5.6				
Conflict of Interest	CCC-304 E	DBWSC 1 4						
Contract Uniformity	D(F)	31						
Contractor Name Change	CCC-304	DBWSC 4						
Contractor's Release	F							
Coordination							VII	
Corporate Qualifications	CCC-304	DBWSC 5						
Cost Effectiveness	A	5.D.25						
Costs for Admin, Planning, Evaluation and QM							II	
Covenant Against Contingent Fees	D(F)	21						
Data Collection and Reporting Requirements	A	5.H	3 5	3.14 5.6				99-14 01-10 01-08 02-09
Data Elements - CARE Act Data Report (CADR)	A	Attachment I	3	3.16			III	
Day or Respite Care for Eligible Individuals						2.19		
Debarment and Suspension Certification	D(F)	19	4	4.15				
Developmental Services for HIV+ Children						2.5		
Disputes	C (GTC 304)	6						
Disputes Resolution Process/Grievance Procedures	D(F)	15	5	5.4				98-05

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Documents, Publications and Written Reports	D(F)	14	4	4.4				
Domestic Partners	CCC-304	CCC 8						
Drug Free Workplace	CCC-304	CCC 2						
Emergency Assistance for Eligible Individuals						2.6		
Encumbrances			3	3.8				
Equal Opportunity Requirements	D(F)	1						
Equipment - Inventory/Disposition of DHS-Funded Equipment	H							
Equipment - Procurement Rules	D(F)	3						
Equipment - Purchased with DHS Funds	G							
Equipment - Ownership/Inventory/Disposition	D(F)	4						
Expense Allowability/Fiscal Documentation	B	7						
Expatriate Corporations	CCC-304	CCC 6						
Federal Contract Funds	D(F)	9						
Final Invoice	B	5						
Financial Status Report	I		Exhibit 8					
Fiscal Agent - Responsibilities/Requirements			4	4.1				
For-Profit Service Providers			4	24		4		97-02 97-04
Form 700 - Statement of Economic Interests								02-07
Freeze Exemptions	E	5						

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Funeral and Burial Expenses						2.7		
Generated Revenues - Agreement	E	6						
Glossary of CARE Act Terms			Exhibit 24				X	
Governing Law	C (GTC 304)	14						
Grants Management							II	
Health Insurance Co-payments and Deductibles						2.2		
HIV Diagnostics & Laboratory Tests								00-01
Housing Referral Services and Short Term Emergency Housing Needs								99-08
Hospice Care for Eligible Individuals						2.21		
HRSA Training								04-02
Human Subjects Use Requirements	D(F)	17						
Income Restrictions	D(F)	6						
Indemnification	C (GTC 304)	5						
Independent Contractor	C (GTC 304)	8						
Insurance - Fiscal Agent	E	5						
Insurance - Service Provider	K	12						
Invoicing and Payment	B	1	3	3.10				97-12 99-15
Invoicing and Payment - Subcontractor	A	5.D.21						
Invoice Detail			Exhibit 7					
Invoice Format	B	Attachment IV	Exhibit 6					

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Key Points of Entry	A	5.D.3	Exhibit 17					
Labor Code/Workers' Compensation	CCC-304	DBWSC 2						
Legal Services	CCC-304	CCC 5				2.9		
Line Item Shifts	B	6	3	3.8				
Licensure and Certification - Service Provider	K	13						
Lobbying	D(F)	32						
Low Income Individuals	A	5.D.6; 5.D.7						
Management Memo's (MM's)	A	5.D.28	4	4.6				
Matching Fund Requirements							II	
Medication Coverage								04-05
Medi-Cal Certification	A	5.D.16	4	4.2				
Meetings	A	5.J	4	4.4				
Mileage					2			02-08
Monitoring Activities	A	5.E	3	3.13			II	99-07
Monitoring Tools			Exhibit 27					
National Labor Relations Board Certification	CCC-304	CCC 3						
Needs Assessment Process	A	5.D.15	4	4.9				00-04
Non-Discrimination Clause	C (GTC 304)	10						
Novation Requirements	D(F)	18						
Officials Not to Benefit	D(F)	24						
Organization Charts			Exhibit 15		3			

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Outreach						3		99-07
Overpayments - Recovery of	B	8						
Partner Counseling and Referral Service (PCRS)	A	5.F	2 Exhibit 14	2.13				
Pastoral Counseling for Eligible Individuals						2.1		
Payee Data Record Form (STD) 204)	CCC-304	DBWSC 8			8			
Payment Withholds	D(F)	22						
Payer of Last Resort	A	D.5.17	2	2.7		2		
Performance Evaluation	D(F)	23						
Permanency Planning for Eligible Individuals						2.11		
Planning Bodies							VI	
Primary Medical Care	A	5.D.5						
Program Guidance							VIII	
Program Policy Guidance (HRSA/DSS/HAB)	A	Attachment II	2	2.11				
Program Policy Guidance (HRSA/DSS/HAB)			Exhibit 5					98-04
Prohibited Use of State Funds for Software	D(F)	26						
Prompt Payment Act	B	3	3	3.11				
Property Rights	D(F)	10						
Property Taxes						2.12		
Prospective Payment Provisions	B	Attachment V						

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
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Purpose of Funds	A	5.B	2	2.7				
Quality Management			3 4	3.21 4.14			VIII	
Record Retention	D(F)	7						
Record Retention	C	4						
Recreational and Social Activities for Eligible Individuals						2.14		
Recycling Certification	C (GTC 304)	9						
Release of Title II Funding	B	9						
Release Letter	M							
Reporting Requirements	A	5.G	3 Exhibit 10	3.14			III	
Request for Application (RFA) - Process			4	4.5				
Resolution	CCC-304	DBWSC 6						
Resource Inventory								03-01
Rural Areas	A	5.D.4						
Ryan White CARE Act (RWCA) Purpose and Goals			2	2.3			I	
Scope of Work	A							
Service Categories			2 Exhibit 4	2.11	27	2	X	98-04
Services to be Performed	A	5						
Service Delivery Plans	A A	5.D.1 5.D.27	4 Exhibit 20	4.8				03-01

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Service Provider Responsibilities	K		5	5.1				
Signature Cards					6			
Site Inspection	D(F)	8						
Sixty (60%) Percent Restriction Limit	A	5.D.12	5	5.2				
Small, Minority Owned and Women's Businesses	D(F)	28						
Smoke-Free Workplace Certification	D(F)	20						
Special Initiatives			2	2.6			I	
Staff Training						8		
Standard Accounting Practices	A	5.D.24						
Standard Agreement			3 Exhibit 13	3.8				
Statement of Compliance	CCC-304	CCC 1						
Subcontractor Model Elements	K							
Subcontractor Reporting Requirements	A	5.I	5	5.6				
Subcontract Requirements	D(F)	5	4	4.6				
Subject Index/Cross Reference			Exhibit 26					
Substance Abuse Treatment for Eligible Individuals						2.15		
Sweat free Code of Conduct	CCC-304	CCC 7						
Termination for Cause	C (GTC 304)	7						
Termination/Cancellation	E	3						
Third Party Reimbursement			2	2.8				

Exhibit 26

Subject Index/Cross Reference

	Contract		Administrative Manual		Fiscal Instructions	DSS/PPG	Title II Manual	MM's
	Exhibit	Paragraph	Chapter	Page	Page	No.	Section	
Tiered Approach			3	3.5				01-01 01-06
Timeliness	C (GTC 304)	12						
Title I and Title II Policies							IV	
Title II Program Categories			2	2.1			V	
Training Seminars, Workshops, Conferences - Prior Approval	D(F)	12						
Transportation for Eligible Individuals						2.22		
Travel and Per Diem	D(F)	2			1			02-08
Unenforceable Provision	C (GTC 304)	17						
Union Activities	C (GTC 304)	18						
Union Organizing	CCC-304 D(F)	CCC 4 30						
University of California Mutual Indemnification	D(F)	27						
Use of Funds	A	5.C	2	2.7		2		97-02 98-04
Vision Care for Eligible Individuals						2.16		
Vocational, Employment, and Employment Readiness Services						2.17		97-14
Water Filters for Eligible Individuals						2.23		
Women, Infants, Children, and Youth (WICY)	A	5.D.9-10	2	2.8				01-08
Year 2000 Compliance	D(F)	25						

Office of AIDS Care Services Program (CSP) Administrative Manual	Exhibit 27 Fiscal Agent and Subcontractor Monitoring Tools
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See attached for:

- Fiscal Agent Monitoring Tool
- Subcontractor Monitoring Tool

Fiscal Agent (FA) Contract Monitoring

Fiscal Agent Contact:		Contract Year Monitored:
Area:	<input type="checkbox"/> EMA <input type="checkbox"/> Tier A <input type="checkbox"/> Tier B	Date(s) of Monitoring:
Monitored by:		Fiscal Agent Signature:
Individuals Present:		Date Corrective Action Plan Implemented:

Fiscal Agent (FA) Contract Monitoring

Table of Contents

Module	Page(s)
Introduction	3
General Instructions.....	3
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Budgets.....	9-10
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Subcontracts.....	19-22
Board Operations.....	23
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Printed Materials.....	25
Client Services	26
General	26-27

Acronyms

AM	Administrative Manual
CADR	CARE Act Data Report
CBO	Community Based Organization
CSP	Care Service Program
DSS	Division of Service Systems (HAB)
EIS	Early Intervention Services
FA	Fiscal Agent
GTC	General Terms and Conditions
HAB	HIV/AIDS Bureau
MM	Management Memo
MOU	Memo of Understanding
PAETC	Pacific AIDS Education and Training Centers
PPG	Program Policy Guidance
RWCA	Ryan White CARE Act
SDP	Service Delivery Plan

Fiscal Agent (FA) Contract Monitoring

Introduction

A. General Instructions

On-site contract monitoring visits are a required component of receiving Ryan White CARE Act funding. The purpose of the visit is to verify contractual compliance and to provide any needed technical assistance. If deficiencies are identified, a corrective plan will be required.

The monitoring is broken down into three (3) different modules: 1) Administrative, 2) Fiscal, and 3) Client Services.

Prior to the site visit, please arrange the following:

- For the appropriate staff to be available, with the required documents (listed in column B in the table below) for review. Documents listed in column C should be made available to CSP staff on request.
- For the appropriate subcontractor staff to be available, at their site of business, with the required documents, listed in column D, for review
- Both the Fiscal Agent and the Subcontractor must have workspace available to CSP staff to conduct their monitoring.

B. Documents to be Reviewed

Column A	Column B	Column C	Column D
Documents to be Reviewed by CSP Staff Prior to Monitoring	Required Fiscal Agent Documents for Review by CSP Staff During Monitoring	Documents That May Be Reviewed During Monitoring	Required Subcontractor Documents for Review by CSP Staff During Monitoring
▪ Application (original and latest applications)	▪ Subcontractor Contracts	▪ Administrative Policies and Procedures Manual	▪ Contracts
▪ Notice of Grant Award	▪ Any Formal Contract Amendments	▪ Staff Meeting Minutes and Agendas	▪ Any Formal Contract Amendments
▪ Contracts and Amendments/MOUs	▪ Correspondence to and from the State for Contractual Change Approvals	▪ Policies and procedures manuals	▪ Travel Reimbursement Rates
▪ List of Equipment Loaned or Purchased with RWCA funds	▪ Travel Reimbursement Rates	▪ Travel Claims (if RWCA funds utilized to pay for travel) <i>(for both</i>	▪ Policies and Procedures Manuals

Fiscal Agent (FA) Contract Monitoring

Column A	Column B	Column C	Column D
Documents to be Reviewed by CSP Staff Prior to Monitoring	Required Fiscal Agent Documents for Review by CSP Staff During Monitoring	Documents That May Be Reviewed During Monitoring	Required Subcontractor Documents for Review by CSP Staff During Monitoring
(e.g., computers, printers, FAX machines, telephones, etc.)		<i>FA and subcontractor</i>	
<ul style="list-style-type: none"> Organizational chart 	<ul style="list-style-type: none"> Copy of materials published with rwca funds 	<ul style="list-style-type: none"> Epidemiologic Information Documents (<i>for both FA and subcontractor</i>) 	<ul style="list-style-type: none"> Standards for limitations of rwca funded emergency assistance category
<ul style="list-style-type: none"> Data Collection and Reports 	<ul style="list-style-type: none"> Standards for Limitations of RWCA funded Emergency Assistance Category 	<ul style="list-style-type: none"> Needs assessment, process, and data (client service data, satisfaction surveys) 	<ul style="list-style-type: none"> Epidemiologic Information Documents (clients and service data)
<ul style="list-style-type: none"> Quality Management Plans and Reports 	<ul style="list-style-type: none"> Current Budgets for Fiscal Agent and Subcontractors 		<ul style="list-style-type: none"> Invoices With Back Up Documentation, Including Tracking Of Personnel Time
<ul style="list-style-type: none"> Latest audit site review report 	<ul style="list-style-type: none"> Subcontractor invoices 		<ul style="list-style-type: none"> Budget revisions
<ul style="list-style-type: none"> Advisory group meeting guidelines 	<ul style="list-style-type: none"> Budget revisions 		<ul style="list-style-type: none"> Equipment inventory (if purchased with RWCA funds)
<ul style="list-style-type: none"> Advisory group meeting minutes 	<ul style="list-style-type: none"> Account information for any funds generated by RWCA funds 		<ul style="list-style-type: none"> Account information for any funds generated by RWCA funds (<i>CBOs</i>)
<ul style="list-style-type: none"> Service delivery plan 	<ul style="list-style-type: none"> Subcontractor reports 		<ul style="list-style-type: none"> Any Reports Provided to Fiscal Agent, CADR, quarterly, client level data
<ul style="list-style-type: none"> Mid-Year and Year-End Financial Reports 	<ul style="list-style-type: none"> Fiscal Agent Review Site review of Subcontractor 		
<ul style="list-style-type: none"> List of Subcontractors 	<ul style="list-style-type: none"> Equipment Inventory (purchased with RWCA funds) 		
	<ul style="list-style-type: none"> CBOs Only – Board Composition, Structure, and Affiliations (e.g., officer positions, committees, etc.) 		
	<ul style="list-style-type: none"> CBOs Only – Board and Committee Minutes and Agendas 		
	<ul style="list-style-type: none"> Invoices With Back Up Documentation, Including Tracking Of Personnel Time 		

Fiscal Agent (FA) Contract Monitoring

FISCAL MONITORING				
INVOICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit B.1 B.4.C B.7	Invoices submitted: <ul style="list-style-type: none"> ▪ Timely ▪ Accurately ▪ Appropriate documentation <i>OA Reviews Prior to Site Visit</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Number reviewed: Number late: % Number inaccurate: % Number with backup documentation: % Comments:		
Contract Exhibit B.5	Final invoice was submitted within 90 calendar days of the contract expiration date <i>OA Reviews Prior to Site Visit</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Date final invoice received: Comments:		

Fiscal Agent (FA) Contract Monitoring

FISCAL MONITORING				
INVOICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit C.4	Fiscal agent maintained records of approved expenditures for three (3) years following the date of final authorized payment (or longer if required by Exhibit D(F), paragraph 7	<input type="checkbox"/> Yes <input type="checkbox"/> No Records are kept where? How long? Comments:		
Contract Exhibit A.21 AM 4.3	Subcontractor invoices are paid within 45 days of receipt	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.22	Fiscal agent has a process in place to ensure that no funds are carried over into subsequent contract years <ul style="list-style-type: none"> ▪ vouchers ▪ bulk purchases 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

FISCAL MONITORING				
INVOICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
FISCAL MONITORING				
LINE ITEM SHIFTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit B.6.A AM 3.8	Line item shifts received prior state approval <i>OA Reviews Prior to Site Visit</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit B.6.A AM 3.8	Line item shifts did not exceed 15% of the contract total without prior approval	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

FISCAL MONITORING				
INVOICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit B.6.C AM 3.8	Written line item shifts adhere to State requirements regarding the process in the administrative manual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit B.6	Formal contract amendment prepared for line item shifts over 15% or \$100,000	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

FISCAL MONITORING				
BUDGETS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.6 AM 3.8	Fiscal agent notifies OA of any changing in funding allocations among subcontractors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit A.9-10	Minimum funds allocated for Women, Infants, Children and Youth are tracked and spent Youth 13-24 Years	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Method of tracking: <input type="checkbox"/> Actual expenditures <input type="checkbox"/> Estimate If estimate, method used: Comments:		
Contract Exhibit A.14.a-b AM 4.12	Fiscal agent used 10% or less of the total allocation for administrative services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

FISCAL MONITORING				
BUDGETS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.15	If fiscal agent received approval for 5% needs assessment, were those funds accounted for	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit A.I	Fiscal agent submitted a list of subcontractors, total funds allocated and budget and budget justifications <i>OA Reviews Prior to Site Visit</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.6	Changes in fiscal agent's scope of work approved in writing by the State prior to change	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit A.D.1-3 A.D.26 Management Memo 00-04	Fiscal agent has provided oversight in developing an inclusive community planning process <ul style="list-style-type: none"> ▪ Required input ▪ Required consultation ▪ Service delivery plan, adjusted annually as needed ▪ Needs assessments, adjusted annually as needed 	<input type="checkbox"/> Yes <input type="checkbox"/> No Date service delivery plan adjusted? Date last full needs assessment conducted? Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.17 DSS/PPG 2 AM 2.7	Fiscal agent has a process in place to ensure RWCA funds are payer of last resort	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.18 DSS/PPG 2	Fiscal agent has a process in place to ensure that no funds are used to make cash payments to clients	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.19	Fiscal agent has a process in place to ensure that no funds are used to purchase or improve (other than minor remodeling) any building or other facility.	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.20 DSS/PPG 2.8	Fiscal agent has a process in place to ensure that no funds are used pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.25	Fiscal agent annually evaluates the cost effectiveness of administrative expenses and services provided	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.29 AM 2.9	Fiscal agent complies with the requirements regarding imposition of charges for services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.G A.H	Fiscal agent complies with all reporting requirements, including financial status reports, the CADR, and quarterly client level data	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.J AM 4.4	Fiscal agent makes staff available to the State for trainings and meetings	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit E.5	Fiscal agent has provided OA with evidence of insurance that will remain in effect at all times during the term of the contract	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Have they submitted the certificate? Is DHS listed as additional insured? Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit D(F).13.a-e AM 5.6	All records with personally identifying client information are kept confidential as is required by all applicable Federal and State laws	<input type="checkbox"/> Yes <input type="checkbox"/> No Internal processes Records never left unattended Confidential FAX Taking records on home site visits Keeping out of janitorial staff access Comments:		
Contract Exhibit A.D.23	Fiscal agent ensures that the goals and objectives are completed as detailed in the application Service Delivery Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit E.6.C	Fiscal agent received written approval from OA to use accrued revenues to defray costs or improve the quality of services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit A.24 D(F).16 AM 4.11	Fiscal agent and subcontractor audits completed and submitted as required	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit G H D(F).4	Equipment provided or purchased was inventoried (with annual inventory submitted to the State), tagged, maintained, and necessary repairs made at no cost to the contract	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit D(F).32.a-b D(F).Attach 1 D(F).Attach 2	Fiscal agent completed "Certification Regarding Lobbying" for contracts over \$100,000 and the "Disclosure of Lobbying Activities" if the fiscal agent agreed to make non-appropriated fund payments in connection with this grant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable if County Health Department Comments:		
Contract Exhibit D(F).2	Travel reimbursement rates are consistent with the contract-identified rates. Exceptions to travel reimbursement rates were submitted in writing to OA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable if RWCA Funds Not Used Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit D(F).1	Fiscal agent meets the Federal Equal Opportunity Clause	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Is there an EOC poster? Comments:		
www.dhs.ca.gov/aids/programs/care/manual.htm	Does the fiscal agent have a current copy of the CSP Administrative Manual?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SUBCONTRACTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.12	Fiscal agent ensures that RWCA funds do not comprise more than 60% of any subcontractor's total budget	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit K AM 5.2	Subcontracts incorporate the requirements of the prime contract between the State and the fiscal agent	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.F AM 4.4	Fiscal agent ensures that all subcontracts include language requiring clients be informed of the availability of HIV Partner Counseling and Referral Services (PCRS)	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SUBCONTRACTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.C A.D.23 DSS/PPG 2	Fiscal agent ensures that services provided under the subcontract fall within the legislatively defined range of services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
MM 97-02 DSS/PPG 4	Fiscal agent ensures that service providers are non-profit, or if for-profit, that there are no non-profits available to provide services	<input type="checkbox"/> Yes <input type="checkbox"/> No Does the fiscal agent review or have a copy of the agency's federal non-profit IRS certification (5013C)? If use a for profit agency, is there a justification? Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SUBCONTRACTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
MM 97-04 DSS/PPG 4	Fiscal agent ensures that RFP process is an open and competitive process. If a service provider is a sole source, the fiscal agent has submitted justification to OA	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
MM 98-05	Fiscal agent ensures appropriate RFP appeal process is published and used	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit A.D.6 A.D.8	Fiscal agent ensures that subcontractor's programs provide outreach to low-income individuals with HIV disease and informs them of all services available	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
SUBCONTRACTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.16 www.hrsa.gov/financeMC AM 4.2	Fiscal agent has ensured that subcontractors who provide Medi-Cal reimbursable services are Medi-Cal certified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit D(F).19 AM 4.14 www.medi-cal.ca.gov AM 4.15	Fiscal agent has documented that subcontractors are not on the federal suspension and debarment list	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.E.1 AM 3.14	Fiscal agent conducts site visits and documents and monitors the activities of subcontractors at least once a year	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
BOARD OPERATIONS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
	Does the Board hold regularly scheduled meetings as stipulated in the guidelines? (CBOs only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
	Are an agenda and complete minutes kept for each Board meeting? (CBOs only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
FACILITY				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
CCC-304, DBWSC.3	All buildings used for public meetings or services are handicapped accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

ADMINISTRATION				
PRINTED MATERIALS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit D(F).10 D(F).14 AM 4.4	Did the contractor print any literature, including educational and promotional materials, with RWCA funds?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit D(F).10 D(F).14 AM 4.4	If yes, did the literature indicate that the contractor's services were supported by RWCA funds?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

CLIENT SERVICES				
GENERAL				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.13 DSS/PPG 1	Fiscal agent has a process to ensure that clients are eligible for services <ul style="list-style-type: none"> ▪ proof of status ▪ financial forms, including insurance coverage 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.5.C DSS/PPG 2 MM 97-02	Fiscal agent ensures that there is documentation that substantiates the need for services and that services contribute to the continuum of care <ul style="list-style-type: none"> ▪ transportation ▪ housing ▪ food vouchers 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Fiscal Agent (FA) Contract Monitoring

CLIENT SERVICES				
GENERAL				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.4	Fiscal agent ensures that subcontractor services for individuals in rural areas have access to case management services that link available community support services to specialized medical services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

Subcontractor Contact:	
Subcontractor:	Contract Year Monitored:
Area:	Date(s) of Monitoring:
Monitored by:	Subcontractor Signature:
Individuals Present:	Date Corrective Action Plan Implemented:
	Fiscal Agent Signature:

Subcontractor Contract Monitoring

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Acronyms

AM	Administrative Manual
CADR	CARE Act Data Report
CBO	Community Based Organization
CSP	Care Service Program
DSS	Division of Service Systems (HAB)
EIS	Early Intervention Services
FA	Fiscal Agent
GTC	General Terms and Conditions
HAB	HIV/AIDS Bureau
MM	Management Memo
MOU	Memo of Understanding
PAETC	Pacific AIDS Education and Training Centers
PPG	Program Policy Guidance
RWCA	Ryan White CARE Act
SDP	Service Delivery Plan

Subcontractor Contract Monitoring

FISCAL MONITORING				
INVOICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit B.4.C	Invoices are supported by appropriate documentation	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit B.4.C	Invoices received from subcontractors or fee-for-services providers are supported by appropriate documentation <i>(only for those subcontractors that subcontract out)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Subcontractor Contract Monitoring

FISCAL MONITORING				
INVOICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit C.4	Subcontractor maintained records of approved expenditures for a minimum of three (3) years following the date final authorized payment or later if involved in legislation per Exhibit D(F), section 7a-c.	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

FISCAL MONITORING				
LINE ITEM SHIFTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit B.6.A	Line item shifts received prior fiscal agent approval	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit B.6.a	Line item shifts did not exceed 15% of the contract total	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit B.6.C AM 3.8	Written line item shifts adhere to State requirements regarding the process in the administrative manual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Subcontractor Contract Monitoring

FISCAL MONITORING				
LINE ITEM SHIFTS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit B.6	Formal contract amendment prepared for line item shifts over 15% or \$100,000	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Subcontractor Contract Monitoring

FISCAL MONITORING				
BUDGETS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
AM 3.8	Budget revisions were approved by fiscal agent prior to billing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit A.D.12	RWCA funds do not comprise more that 60% of total budget	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract	Minimum funds	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Subcontractor Contract Monitoring

FISCAL MONITORING				
BUDGETS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Exhibit A.D.9-10	allocated for Women, Infants, Children and Youth (WICY) Youth: Ages 13-24	Comments:		
AM 3.8	Subcontractor budget detail changes did not alter the performance of the scope of work and/or increase or decrease any line item total beyond line item shift authority	<input type="checkbox"/> Yes <input type="checkbox"/> No Have the subcontractors changed services that they provide? If so, was there a change in the subcontract for scope of work? Was the State notified in writing for approval? Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit K.3	Subcontracts contain requirements in the prime contract with the fiscal agent relative to the subcontractor <i>(only if subcontractor subcontracts out)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
AM 4.14	Subcontractor has a continuous quality improvement system	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.17 DSS/PPG 2 AM 2.8	Subcontractor has a process in place to ensure that RWCA funds are payer of last resort <ul style="list-style-type: none"> ▪ insurance ▪ other programs 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit	Subcontractor informs clients of	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
A.F AM 2.13	the availability of HIV Partner Counseling and Referral Services (PCRS)	Comments:		
AM 5.6	Subcontractor provided reports as required in their contract with fiscal agent <ul style="list-style-type: none"> ▪ mid-year and year-end reports ▪ quarterly client level data ▪ CADR 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit K.9	Subcontractor has a process to ensure	<input type="checkbox"/> Yes <input type="checkbox"/> No Internal processes		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
AM 5.6	confidentiality of public health records	Records never left unattended Confidential FAX Taking records on home site visits Keeping out of janitorial staff access Private space for providing Case Management Comments:		
Contract Exhibit G H D(F).4	Equipment provided or purchased was inventoried, tagged, maintained, and any necessary repair made at no cost to the prime contract with the fiscal agent	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable (if not paid for with RWCA funds) Comments:		
Contract Exhibit G H	Equipment provided or purchased was replaced if lost or	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable (if not paid for with RWCA funds) Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
D(F).4	stolen at no cost to the prime contract with the fiscal agent			
Contract Exhibit D(F).2	Travel reimbursement rates are consistent with the contract-identified rates. Exceptions to the rates were submitted in writing to the fiscal agent and approved	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable (if not paid for with RWCA funds) Comments:		
Contract Exhibit A.D.19	Subcontractor did not use funds to purchase or improve buildings or facilities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit D(F).1	Subcontractor meets the Federal Equal Opportunity Clause	<input type="checkbox"/> Yes <input type="checkbox"/> No Is there an EOC poster? Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.C	Documentation exists that RWCA funds are utilized in coordination with other local, state, and federal housing programs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
DSS/PPG 1	Documentation for planning long-term permanent and stable living situation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit C.10 K.10 GTC304.10	Subcontractor complies with the non-discrimination provisions of the prime contract	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit K.11	Subcontractor employee training and preparation conform to requirements of the program and all required licenses are current. ▪ PAETC	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit K.12	Subcontractor maintains at all times during the contract, adequate insurance covering liability, worker's compensation, automobile, and malpractice	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit K.13	Subcontractor maintains licensure and certification requirements at all times during the subcontract	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
	<i>(only for those subcontractors that subcontract out)</i>			
www.dhs.gov/aids/programs/care/manual.htm	Subcontractor has copy of CSP Administrative Manual	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.23	Subcontractor has copies of fiscal agent Service Delivery Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit A.D.23	Evidence that subcontractor is meeting goals and objectives submitted to fiscal agent <i>(reporting effective indicators and</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
SCOPE OF WORK				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
	<i>measurements</i> ▪ SDP			

Subcontractor Contract Monitoring

ADMINISTRATION				
FACILITY				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.3	Hours of operation	Comments: Are there provisions for access to aftercare hours/crisis intervention services (e.g., on-call system, staff beepers, etc.)		
CCC-304, DBWSC.3	All buildings used for public meetings or services are handicapped accessible	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

ADMINISTRATION				
PRINTED MATERIALS				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Impemented
Contract Exhibit D(F).10 D(F).14 AM 4.4	Did the subcontractor print any literature, including educational and promotional materials, with RWCA funds?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		
Contract Exhibit D(F).10 D(F).14 AM 4.4	If yes, did the literature indicate that the contractor's services were supported by RWCA funds?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Contract Exhibit D(F).10 D(F).14 AM 4.4	Proposed publicity pertaining to the contract submitted to fiscal agent and received approval prior to release	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Comments:		

Subcontractor Contract Monitoring

CLIENT SERVICES				
GENERAL				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.13 DSS/PPG 1	Subcontractor has a process to ensure that clients are eligible for services <ul style="list-style-type: none"> ▪ proof of status ▪ financial forms, including insurance coverage 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2	Services provided fall within the legislatively defined range of services <ul style="list-style-type: none"> ▪ application 	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

CLIENT SERVICES				
GENERAL				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Contract Exhibit A.D.4	Subcontractor ensures that in the case of services for individuals residing in rural areas, it shall deliver case management services that link available community support services to appropriate specialized medical services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

CLIENT SERVICES – PRIMARY MEDICAL CARE				
<ul style="list-style-type: none"> Are there provisions for access to aftercare hours/crisis intervention services (e.g., on-call system, staff beepers, etc.) Is there a waiting list for services? If yes, how many clients are aware of this service? Are Case Managers reflective of the client population (i.e., cultural, linguistic)? Do Case Managers participate in inter-disciplinary client case conferences? Are Case Management forms and progress notes integrated into medical records? 				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
	Ambulatory and/or Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Case Management Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Mental Health Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Oral Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.15	Substance Abuse Services – Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Substance Abuse Services – Residential	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Home Health: Para-Professional Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Home Health: Professional Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Home Health: Specialized Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Rehabilitation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

CLIENT SERVICES – SUPPORT SERVICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
<ul style="list-style-type: none"> ▪ Criteria Used ▪ Are listings of available housing maintained and updated? ▪ Is there documentation for the necessity of housing services that do not provide direct medical or supportive services but enables client to gain and/or maintain medical care? ▪ Are the legal staff able to provide services sensitive to the cultural and linguistic needs of the served population? ▪ Are there mechanisms in place to facilitate exchange of information between legal services and other service providers? ▪ Taxis? ▪ Bus Passes? 				
	Buddy and/or Companion Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.2	Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Child Welfare Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Child Advocacy	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.19	Day or Respite Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Early Intervention Service (EIS)	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
MM 97-02 DSS/PPG 2.6	Emergency Financial Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Food Bank Home Delivered Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Health Education Risk Reduction	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.20	Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

CLIENT SERVICES – SUPPORT SERVICES				
Citation	Monitoring	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
	Housing Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Housing Related Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.9	Legal Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.11	Permanency Planning	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Psychosocial Support Services	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Referral	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.21	Residential or In-Home Hospice Care	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
DSS/PPG 2.22	Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		

Subcontractor Contract Monitoring

CHART REVIEW				
#	Chart Identifier	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Chart Element 1. Name 2. Intake information 3. Proof of HIV status 4. Financial status 5. Rights 6. Grievances 7. Certification that the housing assistance (if applicable) is essential to the client's eligibility to gain and/or maintain access to HIV related medical care signed by qualified professional (i.e., nurse, case manager, MD or care coordinator) 8. If charges tracked for WICY and/or invoices are by client files, is that documentation in the client file				
1		Missing materials Comments		
2		Missing materials Comments		
3		Missing materials Comments		

Subcontractor Contract Monitoring

CHART REVIEW				
#	Chart Identifier	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Chart Element 1. Name 2. Intake information 3. Proof of HIV status 4. Financial status 5. Rights 6. Grievances 7. Certification that the housing assistance (if applicable) is essential to the client's eligibility to gain and/or maintain access to HIV related medical care signed by qualified professional (i.e., nurse, case manager, MD or care coordinator) 8. If charges tracked for WICY and/or invoices are by client files, is that documentation in the client file				
4		Missing materials Comments		
5		Missing materials Comments		
6		Missing materials Comments		
7		Missing materials		

Subcontractor Contract Monitoring

CHART REVIEW				
#	Chart Identifier	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Chart Element 1. Name 2. Intake information 3. Proof of HIV status 4. Financial status 5. Rights 6. Grievances 7. Certification that the housing assistance (if applicable) is essential to the client's eligibility to gain and/or maintain access to HIV related medical care signed by qualified professional (i.e., nurse, case manager, MD or care coordinator) 8. If charges tracked for WICY and/or invoices are by client files, is that documentation in the client file				
		Comments		
8		Missing materials Comments		
9		Missing materials Comments		
10		Missing materials		

Subcontractor Contract Monitoring

CHART REVIEW				
#	Chart Identifier	Comments (completed by CSP monitor)	Corrective Action (completed by FA)	Date Corrective Action Implemented
Chart Element 1. Name 2. Intake information 3. Proof of HIV status 4. Financial status 5. Rights 6. Grievances 7. Certification that the housing assistance (if applicable) is essential to the client's eligibility to gain and/or maintain access to HIV related medical care signed by qualified professional (i.e., nurse, case manager, MD or care coordinator) 8. If charges tracked for WICY and/or invoices are by client files, is that documentation in the client file				
		Comments		
11		Missing materials Comments		
12		Missing materials Comments		

Office of AIDS Care Services Program (CSP) Administrative Manual	Exhibit 28 Care Services Program 2005 Application Technical Assistance and Forms
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The following exhibit includes:

- 2005 Application Technical Assistance Guide
- 2005 Fiscal Forms
- 2005 Checklist
- 2005 Intent to Provide Services

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Introduction

This technical assistance describes the required documents for entities contracting with the Office of AIDS (OA) for CARE Act funds.

Instructions on completing each required document and sample forms/documents are included in each section of this technical assistance.

Blank documents are included in Appendix 1. A document check-off list is included.

Information on per diem rates is included in this section.

Note

Since this is the second of a three-year contract, once OA has received funding allocations from HRSA and OA has approved all contractor/subcontractor fiscal documents, invoices will be processed for periods beginning April 1, 2005. If adjustments to HRSA funding are made, a contract amendment may be required. If an amendment is required, invoices will continue to be processed, unless an invoice exceeds the adjusted contract amount.

Document Formats

You have two options for completing fiscal documents.

1. Excel: Most fiscal documents have been formatted into Microsoft Excel. All documents are self-totaling.
2. If you do not have a computer, please contact your CSP Advisor for paper copies and then type all documents using the blank forms.

Documents other than fiscal documents:

1. Word for Windows: Tab to a field and enter text.
2. If you do not have a computer, please contact your CSP Advisor for paper copies and then type all documents using the blank forms.

**Per Diem
Reimbursement**

Per diem reimbursement is limited by the State's Department of Personnel Administration. Current rates are:

Lodging (per night, plus tax):

- Statewide (excluding the counties identified below): \$84
- Counties of Los Angeles and San Diego: \$110
- Counties of Alameda, San Francisco, San Mateo, and Santa Clara: \$140

Care Services Program (CSP) 2005 Application Technical Assistance	Section 1 Introduction
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Meals: Breakfast: \$ 6.00
 Lunch: \$10.00
 Dinner: \$18.00

Incidentals: For each 24 hour period, \$6.00

Mileage: \$.34 per mile

Care Services Program (CSP) 2005 Application Technical Assistance	Section 2 Organization Chart
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Organization Chart	Organizational chart(s) of the fiscal agency's division of staffing and management must be submitted to OA.
When Required	Required for each contractor.
Completion Instructions	Include a copy with your budget documents.

Advance Payments

Advance payments of up to 25 percent are permitted to private nonprofit fiscal agents with CARE Act contracts.

- Contracts of **\$200,000 or less** may receive either one or two advances.
- Contracts **over \$200,000** shall receive only one advance.

If you receive:	Then:
One (1) advance	Processing will be delayed until passage of the annual State Budget Act
Two (2) Advances	<ul style="list-style-type: none">• You will receive one advance for up to eight (8) percent, and• One for up to 17 percent after passage of the annual State Budget Act.

When Required

Only when Fiscal Agent desires.

Completion Instructions

There is no form. Write your request on agency letterhead. Include the following in your advance payment request.

- Contract number.
- Contractor name(s).
- County name(s).
- Number of advances:
 - Two Advances:
 - One for up to eight percent, liquidated with the May and June invoice.
 - One for up to 17 percent, liquidated with the September through March invoices.
 - One Advance:
 - For a maximum of 25 percent, liquidated beginning the month after the annual State Budget Act passes and completed by March.
- Bank account number.
- Name and address of bank.

Bank Verification Letter

Bank verification letters provide information to the Office AIDS about the financial institution, fund withdrawal procedures, and provide assurances to the Office of AIDS that funds will be withheld upon our notification.

When Required

Bank verification letters are required if you change banks or have a new fiscal agent.

Do not submit new letters for bank accounts established in previous applications.

Completion Instructions

There is no form. Use the sample wording provided below **on bank letterhead**.

**Bank Verification Letter
Required Wording**

Place this wording in the body of the verification letter:

Reference: (Contract Number)
(Bank Account Number)

(Name of bank) is an existing member of FDIC. We are aware that the above referenced account is of a special nature emanating from an agreement between the California Department of Health Services (DHS), and (fiscal agent's full legal name). The special nature of the above referenced account is as follows:

1. The above referenced account is intended only to receive and disburse moneys advanced by DHS to (fiscal agent's full legal name) for the contract period ending March 31, 2007.
2. (Fiscal agent's full legal name) shall make withdrawals only by check.
3. (Name of bank) is aware of the default provisions in the agreement between the DHS and (fiscal agent's full legal name), and herewith gives its assurances that those provisions are understood, particularly in regard to the bank's responsibilities there under, and specifically upon the happening of any event of default:
 - To withhold further withdrawals from the account by (fiscal agent's full legal name) upon written notification from DHS; and
 - To allow DHS to withdraw all or any part of the balance in the above referenced account by check payable to the "California Department of Health Services," upon notice from DHS, that such a check be issued.

Signature Cards

Signature cards identify who can withdraw funds from the Care Services Program account. The fiscal agent and the Chief, Office of AIDS sign signature cards. This countersigning allows the OA to remove funds as necessary in cases of emergency.

When Required

Signature cards are required:

- From non-profit community-based organizations, who receive advance payments of Ryan White CARE Act funds and who don't already have signature cards on file.
- Due to changes in fiscal agent's designated staff.
- Due to changing banks.
- Due to a change of the OA Chief (you will be notified if this happens)

Completion Instructions

There is no form. Your bank will provide you with signature cards.

- Complete the cards as required by the bank.
- Send the cards to the OA for signature.
- OA will return the signed original cards to the bank.

Authorization to Bind Corporation

This document is completed by non-profit community-based organizations acting as fiscal agents.

When Required

New authorizations are only required:

- Due to a change in agency
- Due to a change in authorization to sign monthly invoices
- Due to a change in board Chairperson

Completion Instructions

There is no form. Using the language provided below, submit the document on the agency's letterhead.

Required Wording

"The Board of Directors of the (corporation name) in a duly executed meeting held (date) and where a quorum was present resolved to authorize (name and title) to sign and negotiate the Care Services Program Grant and any contract that may result. In addition, we authorize the following person(s) to sign monthly invoices: (names and titles as appropriate).

The undersigned hereby affirms that the statements contained in this application are true and complete to the best of the applicant's knowledge and accepts as a condition of Contract/Grant Award, the obligation to comply with the applicable state and federal requirements, policies, standards and regulations. The undersigned recognized that this is a public document and open to public inspections."

(Board Chairperson and date)

**Payee Data Record
(Std. 204)**

Payee Data Records provide tax information to the State.

When Required

Only non-profit community-based organizations acting as fiscal agent complete a Payee Data Record.

1. Not required if no changes from last year.
2. Required if there is a change in:
 - Fiscal agent
 - Business name
 - Entity type
 - Taxpayer ID number
 - Residency state
 - Authorized vendor representative

Completion Instructions

To obtain copies of the Payee Data Records, go to www.dhs.ca.gov/aids/programs/care/manual.htm and click on the "Forms" link.

Complete all information, making sure Box 6 is completed with the following:

Department of Health Services/Office of AIDS
Care Services Program, ATTN: Your Care Services
Advisor
MS 7700
P.O. Box 997426
Sacramento, CA 95899-7426
Phone: (916) 449-5955
Fax: (916)449-5959
E-Mail: Your Care Services Advisor

Board of Directors' List Non-profit community-based organizations acting as fiscal agent shall provide a listing of the organization's Board of Directors.

When Required Only non-profit community-based organizations acting as fiscal agent complete a list.

Not required if there are no changes from last year.

Required if there is a change in:

- Board members
- Member's names
- Member's addresses or phone numbers

Completion Instructions There is no form. Create a list and provide:
Name, title, address and phone number for each board member.

Five-Line Item Budget

The five-line item budget provides direction to the OA accounting office to pay invoices. It uses four lines to document the way the fiscal agent is billing its ten percent administrative reimbursement. One line documents the cost of services provided to clients and the five percent needs assessment. The fiscal agent completes this document.

When Required

Required for each application.

Definition of Line Items

Line	Item	Explanation
1	Personnel	The total salaries, wages and benefits paid to the fiscal agent's staff.
2	Operating Expenses	The operating expenses incurred by the fiscal agent. Operating expenses are typically those expenses that can be assigned to a specific program. This might include office supplies, postage, telephone, etc.
3	Capital Expenditures	The CARE Act limits equipment purchases. Contact your advisor for information regarding specific equipment requests.
4	Other Costs	This is the total of all subcontracts, including needs assessment funds.
5	Indirect Costs CAUTION: Indirect expenses are limited to 15% of the total personnel costs of the fiscal agent.	Indirect costs are typically those expenses that cannot be assigned to one program. Often this category is used when a fiscal agent has multiple programs and divides the rent, utilities, janitorial services, etc. either equally between programs or based on the percentage of time spent on a program.

- Completion Instructions**
1. Complete the five-line item budget for fiscal year 2005 - 2006.
 2. Ensure the total of lines 1, 2, 3, and 5 equals the fiscal agent's administrative amounts on the budget overview document. Not to exceed 10% of total allocation.
 3. Ensure that line item 4 equals the total of all subcontractors' budgets on the budget overview document and needs assessment fund.

**Sample
Five-Line Item Budget**

Best Ever Fiscal Agent 04-12345

Budget Period

2005-06

Budget Categories		Amount Budgeted
1	Personnel	\$8,142
2	Operating Expenses	\$1,782
3	Capital Expenses	\$0
4	Other Costs	\$108,000
5	Indirect Costs	\$2,076
Total Budget		\$120,000

Budget Overview

This section provides instructions for completing the Budget Overview document. This document is completed by the fiscal agent and indicates how the total grant is allocated between the fiscal agent and subcontractors.

When Required

Required for all applications.

Completion Instructions

1. List all subcontractors in alphabetical order.
2. Enter amount of awards (column will self-total).
3. Ensure that the total awards equal the total grant amount.

Sample

Fiscal Agent and Contract Number

Fiscal Year

Best Ever Fiscal Agent 04-12345

2005-06

Budget Overview

Amount

Fiscal Agent Administrative Funding (not more than 10% of award)

\$12,000

Supplemental Funds (Needs Assessment not more than 5% of award)

\$4,000

Subcontractors:

Addiction Recovery Services

\$7,000

Meals on Wheels

\$15,000

A-1 AIDS Clinic

\$82,000

Total Grant \$120,000

**Fiscal Agent Budget
Summary**

This form identifies the fiscal agent and itemizes the fiscal agent's expenses. Fiscal agents who also provide client services must describe those services and costs using the Subcontractor Budget Detail and Subcontractor Personnel Detail. This information is required by HRSA.

When Required

Required for every application.

Definitions

Indirect Costs

Indirect costs are typically those expenses that cannot be assigned to one program. Often this category is used when a service provider has multiple programs and divides the rent, utilities, janitorial services, etc. either equally between programs or based on the percentage of time spent on a program. Indirect expenses must be identified, see sample for detail required.

Note: Indirect expenses are limited to 15% of the total personnel costs.

Operating Expenses

Operating expenses are typically those expenses that can be assigned to a specific program, but are not essential to the delivery of the service. This might include travel to required meetings, office supplies, postage, facilities operations, telephone, etc. Operating expenses must be itemized, see sample for detail required.

Equipment

The CARE Act limits equipment purchases. Contact your advisor for information regarding a specific equipment request.

Personnel Costs

The total personnel amount from the fiscal agent personnel detail.

Completion Instructions

1. Enter all requested information.
2. This document will self-total. Ensure that the Total Fiscal Agent Budget does not exceed 10% of the total grant.

**Care Services Program (CSP)
2005 Application
Technical Assistance**

**Section 10
Fiscal Agent
Personnel Detail**

SAMPLE

Fiscal Agent Budget Summary

Fiscal Agent and Contract Number

Fiscal Year

Best Ever Fiscal Agent 04-12345

2005-06

Fiscal Agent Name and Address

Best Ever Fiscal Agent, 1970 Broadway, Oakland, CA 94612

Contact Person

Title

E-Mail

Telephone

Fax Number

Mary Jones

Assistant Director

mj@befa.org

510-555-1212

510-555-1212

Ownership Status (check one)

☒ Public/Local ☐ Public/State ☐ Public/Federal ☐ Private/Nonprofit ☐ Incorporated

Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care?

☐ Yes ☒ No

Expense Category

Description

Budgeted Amount

Indirect

Facilities Management (rent, janitorial, security, insurance
(173 mo x 12 mo)

\$1,212

Total Indirect

\$1,212

Operating

Office Supplies, Misc.

\$1,478

Postage (\$10 mo x 12 mo)

\$120

Printing/reproduction (\$6 mo x 12 mo)

\$72

Travel (.34/mile x 400 miles)

\$136

Telephone (70 mo x 12 mo)

\$840

Total Operating

\$2,646

Equipment

\$0

Total Equipment

\$0

Personnel

Total Administrative Personnel

\$8,142

Total Fiscal Agent Budget

\$12,000

**Fiscal Agent Personnel
Detail**

This form identifies the personnel providing administrative services and their salaries funded with the fiscal agent contract. Fiscal agents who also provide client services must describe those positions using the Subcontractor Personnel Detail. This information is required by HRSA.

When Required

Required for every application.

Completion Instructions

1. Complete a personnel description for each person receiving a salary from this contract.
2. If your employees are salaried, enter their percentage of time performing these duties in the box provided.
3. If your employees are hourly rather than salaried, enter their estimated annual hours.
4. Enter the fringe benefits for the employees on this page.
5. If you have more than two staff, complete additional documents.

This document will self-total.

**Care Services Program (CSP)
2005 Application
Technical Assistance**

**Section 10
Fiscal Agent
Personnel Detail**

SAMPLE

Fiscal Agent Personnel Detail					
Fiscal Agent and Contract Number			Fiscal Year		
Best Ever Fiscal Agent 04-12345			2005-06		
Position Title		If vacant, est. hiring date		Staff Last Name, First Initial	
Accounting Officer				Lacey, V	
Duties	Travel Required: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where, when and why travel is necessary		Annual Salary	Percentage of time performing these duties
Provide administration for Title II funds, development, updating and implementation of service delivery plans, oversee maintenance of records, develop processes and procedures to establish and maintain subcontracts; ensure all contract requirements are met; ensure timely and accurate reporting. Travel inside California to attend meetings and training as required by Office of AIDS.				\$47,000	10%
				Hourly Salary	Estimated hours performing these duties
				\$0	0
				Benefits	
				\$797	
Position Title		If vacant, est. hiring date		Staff Last Name, First Initial	
Accounting Clerk				Winters, S.	
Duties	Travel Required: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, include where, when and why travel is necessary		Annual Salary	Percentage of time performing these duties
Prepare Invoices, track expenditures, complete fiscal or other reporting documents as required.				\$23,000	10%
				Hourly Salary	Estimated hours performing these duties
				\$0	0
				Benefits	
				\$345	
Position Title		If vacant, est. hiring date		Staff Last Name, First Initial	
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where, when and why travel is necessary		Annual Salary	Percentage of time performing these duties
				Hourly Salary	Estimated hours performing these duties
				Benefits	
Total Personnel Costs, this page					
\$8,142					

**Needs Assessment
Detail**

This form is used to report Needs Assessment Details.
Needs Assessment funds may be disallowed by your
advisor.

When Required

This form is used to report Needs Assessment Details.
Needs Assessment funds may be disallowed by your CSP
Advisor.

Completion Instructions

1. Enter all required information.
2. This document will self-total. Ensure that the amount
awarded is the same as the amount totaled.
3. Needs Assessment costs are shown on the five-line
item budget in the "Other Costs" line item.

SAMPLE

Needs Assessment Detail			
Fiscal Agent and Contract Number		Fiscal Year	
Best Ever Fiscal Agent 04-12345		2005-06	
Subcontractor Name and Address			
Frank Howard 789 Blue Jay Road, Oakland, CA 94612			
Contact Person	Amount Awarded	Telephone	Fax Number
Frank Howard	\$4,000	(510) 555-1212	(805) 555-1213
Ownership Status (check one)			
<input checked="" type="checkbox"/> Public/Local <input type="checkbox"/> Public/State <input type="checkbox"/> Public/Federal <input type="checkbox"/> Private/Nonprofit <input type="checkbox"/> Private/For Profit <input type="checkbox"/> Incorporated			
Expense Category	Description	Budgeted Amount	
	Indirect		
		\$0	
	Total Indirect	\$0	
	Operating		
	Total Operating	\$0	
	Personnel	\$4,000	
	Fringe Benefit	\$0	
Total Needs Assessment Budget			\$4,000
Needs Assessment Personnel			
Title		Contract Start Date	Consultant Last Name, First Initial
Consultant		April 1, 2004	Frank Howard
Duties	Travel Required: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where, when and why necessary	Salary Paid by this Contract
Provide consulting services to Alameda County to aid in gathering, performing, tabulating and analyzing need assessment data.			\$4,000

**Subcontractor Budget
Detail**

This section provides instructions for completing the Subcontractor Budget Detail document. The Subcontractor Budget Detail provides information on items such as: estimated number of clients to be served, service costs, personnel costs and operating expenses.

NOTE: Subcontractor administration fees that exceed 25% of their award require written justification.

When Required

Required for each subcontractor.

**Emergency Financial
Assistance**

This category may be used for utilities or medication only. If you fund this category you must develop a policy that:

- Identifies the services that will be provided
- Creates guidelines that assure limited amounts, limited use and limit the period of time that an individual may utilize this category.

You must specify utilities or medications in the invoice backup detail.

Directions

Each expense category requires a description of the expense (services, indirect, etc.), a budgeted amount, and for services the estimated number of clients to be served.

This section provides definitions of expense categories. Your accounting systems determine whether or not you use indirect expenses, operating expenses, or both. Either category must be itemized.

Column Title	Directions
Service Category	Itemize each category of service provided. The only allowable service categories are those listed in Section 14 of this document. Services that fall under the defined category of "Other Services" must be individually identified. Failure to use the appropriate service categories may result in delayed contracts and delayed reimbursement.

	If travel is required to perform the duties (case manager seeing clients in their homes) then the expenses associated with the travel are part of the service and not listed under "Operating Expenses."
Estimated Clients Served	Enter the estimated number of clients you expect to serve.
Budgeted Amount	Enter the total amount assigned to the service.
Indirect Costs Note: Indirect expenses are limited to 15% of the total personnel costs.	Indirect expenses are typically those expenses that cannot be assigned to one program. Often this category is used when a service provider has multiple programs and divides the rent, utilities, janitorial services, etc., either equally between programs or based on the percentage of time spent on a program. Indirect expenses must be identified.
Operating Expenses NOTE: Subcontractor administration fees that exceed 25% of their award require justification.	Operating expenses are typically those expenses that can be assigned to a specific program but are not dedicated to providing the service. For example, a case manager who travels to see clients. The travel expense is part of that service, not an operating expense. Budgeting travel for state-required training would be an operating expense. Operating expenses might include office supplies, postage, telephone, etc.
Equipment	The CARE Act limits equipment purchases. Contact the fiscal agent for information regarding a specific equipment request.

**Administrative
Personnel**

NOTE: Subcontractor administration fees that exceed 25% of their award require justification.

Enter the total administrative personnel amount from the Subcontractor Personnel Detail.

Administrative Support is defined as services provided that are not direct services to clients as described in the Services Section of the Subcontract Budget Detail. For example, administrative costs would include: the executive director, clinic supervisor, accounting staff, receptionist, etc.

Sample Explanation

In the sample, A-1 AIDS Clinic was awarded \$82,000. They are providing Case Management Services, Substance Abuse Treatment , and Ambulatory/Outpatient Medical Care.

These are appropriate categories. HRSA requires that funds should be prioritized and allocated to essential core services.

SAMPLE

**Care Services Program (CSP)
2005 Application
Technical Assistance**

**Section 12
Subcontractor
Budget Detail**

Subcontractor Budget Detail				
Fiscal Agent and Contract Number			Fiscal Year	
Best Ever Fiscal Agent 04-12345			2005-06	
Subcontractor Name and Address				
A-1 AIDS Clinic, 1970 Broadway, Oakland, CA 94612				
Contact Person	Title	Telephone	Fax Number	E-mail
Michael Smith	Director	(510) 123-4567	(510) 345-6789	msmith@a-1ac.org
Ownership Status:				
<input checked="" type="checkbox"/> Public/Local <input type="checkbox"/> Public/State <input type="checkbox"/> Public/Federal <input type="checkbox"/> Private/Nonprofit <input type="checkbox"/> Private/For Profit <input type="checkbox"/> Incorporated				
Bid Status (check one)				
<input type="checkbox"/> Sole Source (justification attached) <input checked="" type="checkbox"/> Competitive Bid				
Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care?				
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Expense Category	Description	Est. Clients Served	Budgeted Amount	
Services	Ambulatory/Outpatient Medical Care	150	\$24,224	
	Case Management	150	\$38,484	
	Substance Abuse Services	75	\$8,561	
	Total Services		\$71,269	
Indirect	Facilities Management (Rent, Janitorial, security, insurance) (\$500 mo x 12 mo)		\$6,000	
	Total Indirect		\$6,000	
Operating	Office Supplies		\$2,344	
	Postage (\$15/mo x 12 mo)		\$180	
	Travel for Training and Conference (.34/mile x 300 miles and per diem)		\$200	
	Telephone, fax etc. (\$30/mo x 12 mo)		\$360	
	Total Operating		\$3,080	
Equipment			\$0	
	Total Equipment		\$0	
Administrative Personnel		Total Administrative Personnel	\$1,647	
Total Subcontractor Budget			\$82,000	

**Subcontractor
Personnel Detail**

This document provides information about all staff, either administrative or those who provide direct client services as described in the Services Section of the Subcontractor Budget Detail.

If a portion of a staff member's time is administrative and the other is providing direct client service, complete two position sections of the personnel detail; one for administrative duties and the other for direct client service.

When Required

Required for all subcontractors. Required for fiscal agents who also provide services.

**Completion
Instructions**

1. Enter all information requested.
2. Specify all duties performed by each person.
3. Administrative Support is defined as services provided that are not direct services to clients as described in the Services Section of the Subcontract Budget Detail.. For example, administrative costs would include:
 - the executive director, clinic supervisor, accounting staff, receptionist, etc.
4. Enter the percentage of time or hours that a person performs their duties.
5. Use as many pages as necessary to list all personnel.

**Care Services Program (CSP)
2005 Application
Technical Assistance**

**Section 13
Subcontractor
Personnel Detail**

SAMPLE

Subcontractor Personnel Detail

Fiscal Agent and Contract Number

Fiscal Year

Best Ever Fiscal Agent 04-12345

2005-06

Subcontractor Name and Address

A-1 AIDS Clinic, 1970 Broadway, Oakland, CA 94612

Contact Person

Telephone

Fax Number

E-mail

Michael Smith

(510) 123-4567

(510) 345-6789

msmith@a-1ac.org

Position Title	Administrative? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If vacant, est. hiring date	Staff Last Name, First Initial		
Case Manager			Smallburg, S		
Duties	Travel Required: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where, when and why necessary	Annual Salary	Percentage of time performing these duties	Annual salary paid by this contract
Provide Coordinated access to medically appropriate levels of health and support services. Assessment, development of a comprehensive, individualized service plan, plan implementation, medical coordination and follow-up on medical treatments to ensure efficacy. Travel during length of contract to clients' homes within the county area.			38,000	80%	\$30,400
			Hourly Salary	Estimated hours performing these duties	Hourly salary paid by this contract
			0	0	\$0
			Estimated Travel Expense		
			\$1,700		
			Benefits		
			\$6,384		

Position Title	Administrative? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If vacant, est. hiring date	Staff Last Name, First Initial		
Bookkeeper			Perry, W		
Duties	Travel Required: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, include where, when and why necessary	Annual Salary	Percentage of time performing these duties	Annual salary paid by this contract
Create invoices, bill for services, other routine financial services.			\$27,000	5%	\$1,350
			Hourly Salary	Estimated hours performing these duties	Hourly salary paid by this contract
			0	0	\$0
			Estimated Travel Expense		
			\$0		
			Benefits		
			\$297		

Total Personnel Costs, this page

\$40,131

There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
------------------	------------

HEALTH CARE SERVICES

Ambulatory/Outpatient Medical Care

Provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health and nutritional issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

Primary Medical Care for the Treatment of HIV Infection includes the provision of care that is consistent with Public Health Service's Treatment guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Drug Reimbursement Program

Ongoing service/programs to pay for approved pharmaceuticals and or medications for persons with no other payment source. Subcategories include:

- a. **State-Administered AIDS Drug Assistance Program (ADAP).** Authorized under Title II of the CARE Act and provides FDA approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medi-Cal.
- b. **Local/Consortium Drug Reimbursement Program.** A program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program.
Medications include prescription drugs provided through ADAP to prolong life or prevent the

There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
------------------	------------

deterioration of health. The definition *does not include* medications that are dispensed or administered during the course of a regular medical visit or that are considered part of the services provided during that visit. If medications are paid for and dispensed as part of an *Emergency Financial Assistance Program*, they should be reported as such.

Health Insurance

A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health-insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home Health Care

Provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes.

Home Health Professional Care

Provision of services in the home by licensed health care workers, such as nurses.

Home Health Specialized Care

Provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

Oral Health

Diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Hospice Services

- a. **Home-Based Hospice Care.** Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting.
- b. **Residential Hospice Care.** Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal

There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
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stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

Mental Health Services	Psychological and psychiatric treatment and counseling services to individuals with a diagnoses mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
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Nutritional Counseling	Provision of nutrition education and/or counseling by a licensed/registered dietitian outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietician should be provided under <i>Psychosocial support services</i> .
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Rehabilitation Services	Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training services.
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Substance Abuse Services-Outpatient	Provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.
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Substance Abuse Services-Residential	Provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) provided in an inpatient health service setting (short-term).
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Treatment Adherence Services	Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.
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There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
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SUPPORT SERVICES

**Buddy/Companion
Service**

Provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

Child Care Services

Care for the children of clients provided when clients are attending medical or other appointments, Title-related meetings, groups, or training. NOTE: This does not include daycare while the client is at work.

Child Welfare Services

Family preservation/unification, foster care, parenting education, and other child welfare services. Services designed to prevent the break-up of a family and to reunite family members. Foster care assistance to place children under the age of 21 years, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. Other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of HIV-positive children about risks and complications, care-giving needs, and developmental and emotional needs of children.

Case Management

A range of client-centered services that links clients with health care, psychosocial and other services. Case management ensures timely and coordinated access to medically-appropriate levels of health and support services and continuity of care through ongoing assessment of the client's and other key family members' needs and personal support systems. This also includes inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include: (1) initial assessment of

There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
	service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan and client monitoring to assess the efficacy of the plan; and (4) periodic reevaluation and adaptation of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.
Client Advocacy	Provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.
Day or Respite Care	Provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client.
Developmental Assessment/Early Intervention Services	Provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. Involves assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. Includes comprehensive assessment of infants and children taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools.
Early Intervention Services	For Titles I and II are a combination of services that include outreach, HIV counseling, testing, referral and provision of outpatient medical care and supportive services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care.
Emergency Financial Assistance	Provision of short-term payment for essential utilities and for medication assistance when other resources are not

There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
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available.

**Food Bank/Home
Delivered
Meals/Nutritional
Supplements**

Provision of actual food, meals, or nutritional supplements. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

**Health Education/Risk
Reduction**

Provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. This includes the provision of information on medical and psychosocial support services and counseling, to help clients with HIV improve their health status.

Housing Assistance

This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of CARE Act funds for short-term or emergency housing must be linked to medical and/or healthcare or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

**Housing Related
Services**

Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

Legal Services

Provide individuals with assistance related to powers of attorney, do-not-resuscitate orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. Not included are any legal services that arrange for guardianship or adoption of children after the death of the normal caregiver.

Outreach Services

Programs which have as their principal purpose the

There are no changes to the services category definitions for 2005-2006.

Service Category	Definition
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identification of people with HIV disease so that they may become aware of and may be enrolled in care and treatment services (i.e., case finding). Outreach does not include HIV counseling and testing or HIV prevention education. Outreach programs must be planned and delivered in coordination with State and local HIV-prevention outreach program to avoid duplication of efforts, targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, conducted at times and in places where there is a high probability that HIV-infected individuals will be reached; and designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency Planning

Provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Psychosocial Support Services

Provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other HIV-related services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers.

Referral for Health Care/Supportive Services

The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within a case-management system by professional case managers, informally through support staff, or as part of an outreach services program.

Referral to Clinical Research

Provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research involves studies in which new treatments – drugs, diagnostics, procedures, vaccines, and other therapies – are tested in

There are no changes to the services category definitions for 2005-2006.

Service Category

Definition

people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an IRB that initially approves and periodically reviews the research.

Transportation

Conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

- 1. Document Checklist**
- 2. Fiscal Agent Contact**
- 3. Five-line Item Budget**
- 4. Budget Overview (list subcontractors alphabetically)**
- 5. Fiscal Agent Budget Summary**
- 6. Fiscal Agent Personnel Detail**
- 7. Needs Assessment Detail (if applicable)**
- 8. In alphabetical order, for each subcontractor, attach a packet containing the following:**
 - Subcontractor Budget Detail**
 - Subcontractor Services Personnel Detail**

Instructions:

1. Submit documents **in the following order.**
2. Check off each item as attached.
3. Sign and date.

**CARE SERVICES PROGRAM (CSP)
2005 FISCAL DOCUMENTATION
DOCUMENT CHECKLIST**

ITEM	✓	Office of AIDS Use Only
Document Checklist	<input type="checkbox"/>	
Fiscal Agent Contact, <i>only if there are changes.</i>	<input type="checkbox"/>	
Fiscal Agent Organization Chart	<input type="checkbox"/>	
NON-PROFIT CBO ONLY:		
• Request for Advance Payment Letter, <i>if desired.</i>	<input type="checkbox"/>	
• Bank Verification Letter, <i>only if requesting Advance Payment.</i>	<input type="checkbox"/>	
• Bank Signature Cards, <i>only if requesting Advance Payment.</i>	<input type="checkbox"/>	
• Authorization to Bind Corporation, <i>only if there are changes.</i>	<input type="checkbox"/>	
• Payee Data Record, <i>only if there are changes.</i>	<input type="checkbox"/>	
• Board of Directors list, <i>only if there are changes.</i>	<input type="checkbox"/>	
ALL CONTRACTORS:		
Five-line Item Budget	<input type="checkbox"/>	
Budget Overview (list subcontractors alphabetically)	<input type="checkbox"/>	
Fiscal Agent Budget Summary	<input type="checkbox"/>	
Fiscal Agent Personnel Detail	<input type="checkbox"/>	
Needs Assessment Detail (if applicable)	<input type="checkbox"/>	
In alphabetical order, for each subcontractor, attach a packet containing the following:	<input type="checkbox"/>	
• Subcontractor Budget Detail	<input type="checkbox"/>	
• Subcontractor Services Personnel Detail	<input type="checkbox"/>	
DOCUMENT DUE DATES:		
• Contractors will be notified in late March when budget documents are due, after OA has received HRSA allocations for 2005-2006.	<input type="checkbox"/>	
<p>I certify that all documents are completed and attached as indicated. Budget documents have been reviewed for accuracy. I understand this application may be rejected due to budget errors. If rejected, I understand that the contract amendment may be delayed until corrected documents are received. I understand delayed contracts could result in delayed invoice processing.</p>		
Fiscal Agent Signature	Date	

Fiscal Year
2005-06

FISCAL AGENT CONTACTS

The names listed as contacts will be placed on OA mailing lists. These individuals will receive information and are responsible to disseminate to advisory boards as applicable, subcontractors and other interested parties.

Fiscal Agent

Title	Taxpayer I.D. Number
Organization	
Address	
Phone Number	Fax Number

Agency Official with Board Authority to Commit Agency to an Agreement

Title	
Organization	
Address	
Phone Number	Fax Number

Five-Line Item Budget

Fiscal Agent and Contract Number

Alameda County 03-75901



Budget Period

2005 - 06



Budget Categories	Amount Budgeted
1 Personnel	\$0
2 Other Costs	\$0
3 Capital Expenses	\$0
4 Other Costs	\$0
5 Indirect Costs	\$0
Total Budget	\$0

Monterey 03-75916

2005-06

Budget Overview

	Amount
Fiscal Agent Administrative Funding (not more than 10% of award)	\$1,500
Supplemental Funds (Needs Assessment not more than 5% of award)	\$0
Subcontractors	
Mono County Public Health	\$13,500
	\$0
Total Grant:	\$15,000

Fiscal Agent Budget Summary

Fiscal Agent and Contract Number		Fiscal Year
<div></div>	<div>▼</div>	<div>2005-2006</div> <div>▼</div>

Fiscal Agent Name and Address

Contact Person	Title	e-MAIL	Telephone	Fax Number
----------------	-------	--------	-----------	------------

Ownership Status (check one)

☐ Public/local

☐ Public/State

☐ Public/Federal

☐ Private/Nonprofit

☐ Incorporated

Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care?

☐ Yes

☐ No

Expense Category	Description	Budgeted Amount
Indirect		
Total Indirect		\$0
Operating		
Total Operating		\$0
Equipment		
Total Equipment		\$0
Personnel	Total Administrative Personnel	
Total Fiscal Agent Budget		\$0

Fiscal Agent Personnel Detail

Fiscal Agent and Contract Number			Fiscal Year		
Action Council of Monterey County 03-75916			2005 - 06		

Position Title			If vacant, est. hiring date		Staff Last Name, First Initial	
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract	
			0	0%	\$0	
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract	
			\$0	0	\$0	
			Benefits \$0			

Position Title			If vacant, est. hiring date		Staff Last Name, First Initial	
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract	
				0%	\$0	
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract	
					\$0	
			Benefits			

Position Title			If vacant, est. hiring date		Staff Last Name, First Initial	
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract	
			0	0%	\$0	
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract	
					\$0	
			Benefits			

Position Title			If vacant, est. hiring date		Staff Last Name, First Initial	
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract	
					\$0	
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract	
					\$0	
			Benefits			

Position Title			If vacant, est. hiring date		Staff Last Name, First Initial	
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract	
					\$0	
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract	
					\$0	
			Benefits			

Total Personnel Costs, this page						\$0
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Needs Assessment Detail

Fiscal Agent and Contract Number

Action Council of Monterey County 03-75916 ▼

Fiscal Year

2005 - 06 ▼

Subcontractor Name and Address

Contact Person

Amount Awarded

Telephone

Fax Number

Ownership Status (check one)

☐

Public/Local

☐

Public/State

☐

Public/Federal

☐

Private/Nonprofit

☐

Incorporated

Expense Category

Description

Budgeted Amount

Indirect

Total Indirect

\$0

Operating

Total Operating

\$0

Personnel

Fringe Benefit

Total Needs Assessment Budget

\$0

Needs Assessment Personnel

Title

Contract Start Date

Last Name, First Initial

Duties

Travel Required:

☐

Yes

☐

No

If yes, include where will travel, when, and why necessary

Salary Paid by this Contract

Subcontractor Budget Detail

Fiscal Agent and Contract Number

Monterey County 03-75916

Fiscal Year

2005-06

Subcontractor Name and Address

Contact Person

Telephone

Fax Number

E-mail

Ownership Status (check one)

☐ Public/Local

☐ Public/State

☐ Public/Federal

☐ Private/Nonprofit

☐ Incorporated

☐ Private/profit

Bid Status (check one)

☐ Sole Source (justification attached)

☐ Competitive Bid

Do members of minority racial/ethnic groups constitute a majority of Board members and/or a majority of staff (volunteer or paid) providing care?

☐ Yes

☐ No

Expense Category	Description	Est. Clients Served	Budgeted Amount
Services			
Total Services			\$0
Indirect			
Total Indirect			\$0
Operating			
Total Operating			\$0
Equipment			
Total Equipment			\$0
Administrative Personnel		Total Administrative Personnel	
Total Subcontractor Budget			\$0

Subcontractor Personnel Detail

Fiscal Agent and Contract Number

Mendocino Community Health Clinic Inc. 03-75912 ▼

Fiscal Year

2005 - 06 ▼

Subcontractor Name and Address

Contact Person

Telephone

Fax Number

E-mail

Position Title	Administrative? <input type="checkbox"/> Yes <input type="checkbox"/> No	If vacant, est. hiring date	Staff Last Name, First Initial		
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract
					\$0
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract
					\$0
			Estimated Travel Expense		
			Benefits		

Position Title	Administrative? <input type="checkbox"/> Yes <input type="checkbox"/> No	If vacant, est. hiring date	Staff Last Name, First Initial		
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract
					\$0
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract
					\$0
			Estimated Travel Expense		
			Benefits		

Position Title	Administrative? <input type="checkbox"/> Yes <input type="checkbox"/> No	If vacant, est. hiring date	Staff Last Name, First Initial		
Duties	Travel Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, include where will travel, when, and why necessary	Annual Salary	Percentage of time performing these duties	Salary paid by this contract
					\$0
			Hourly Salary	Estimated hours performing these duties	Salary paid by this contract
					\$0
			Estimated Travel Expense		
			Benefits		

Total Personnel Costs, this page	\$0
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DEPARTMENT OF HEALTH SERVICES**OFFICE OF AIDS****611 NORTH SEVENTH STREET, SUITE A
SACRAMENTO, CA 95814-0208****OFFICE OF AIDS
HIV Care Consortia****Management Memorandum
Memorandum Number: 01-01****To: Program Fiscal Agents
Consortia Chairs
Services Providers****Date: January 16, 2001****Topic: Notification of Administrative Revisions to Consortia**

The Ryan White CARE Act is entering its eleventh year – the first year after the most recent reauthorization. The revised CARE Act language provides guidance regarding Health Resources Services Administration (HRSA)'s fundamental principals, a priority for the provision of primary medical care, access to primary medical care, and the provision of quality HIV care. This focus and guidance provides an opportunity to affect positive change within the existing system of HIV care. Clearly, we are facing myriad challenges throughout the next few years as we address the changing requirements of HRSA and the state system, and most importantly the needs of our clients.

To prepare for changes related to addressing HRSA's fundamental principals the statewide California HIV Planning Group (CHPG) recommended revisions to the approach utilized to allocate Consortia Program resources. The Office of AIDS (OA), in accepting CHPG's recommendation, recognized that measures to streamline and reduce administrative processes were also required at this time.

The OA is committed to implementation of these changes in a manner that also addresses various administrative and programmatic concerns voiced by fiscal agents, consortia members, clients and service providers. We will begin implementing these changes effective Year 11.

CHPG's recommendation and the resulting changes to the allocation of Consortia Program funds and program administration is further clarified in this management memo.

Tiered Approach

HIV service needs and resources vary significantly in a state as geographically, culturally and economically diverse as California. Service needs of existing and emerging populations, cultural issues, administrative capacity, technical assistance needs, and available funding differs greatly throughout the state; it's imperative that the Consortia Program address these changing needs by maintaining the flexibility needed to address service needs in these varying local environments.

The OA developed a tiered approach to begin addressing two areas of concern identified by various fiscal agents and consortia -- increased administrative responsibilities and imbalanced funding levels. These issues have been addressed through the development of

three categories, or tiers, of counties where funding levels, as well as administrative responsibilities, will be established at a level commensurate with local needs and utilization.

Tier A: Tier A counties are identified as counties with six or fewer Persons Living With AIDS (PLWA) or persons served. Tier A counties will be subject to administrative and funding revisions, as detailed in this management memo. The following counties are in Tier A:

Alpine
Colusa
Del Norte
Glenn
Inyo
Modoc
Mono
Plumas
Sierra

Tier B: Tier B counties are those counties significantly impacted by increased demand for services, as demonstrated through caseload data, increasing persons accessing services, increasing PLWA, decreasing Title II Consortia Program funding, and per capita HIV/AIDS funding that falls below the statewide average. Tier B counties will be subject to funding and administrative revisions as detailed in this management memo. The following counties are in the Tier B category:

Fresno
Kern
Monterey
Santa Cruz
Solano
Stanislaus

Tier C: Tier C counties are those Eligible Metropolitan Area (EMA) and non-EMA counties that do not fall into Tiers A or B, and will not be subject to funding or significant administrative revisions in Year 11.

Administrative Responsibilities

Administrative requirements are being reduced or streamlined where possible in response to contractors' concerns regarding the administrative responsibilities associated with the Consortia Program, especially by contractors with relatively small administrative allocations. The OA acknowledges the difficulties experienced by Tier A contractors in complying with state and federal administrative processes and is developing minimal administrative standards for these counties.

An administrative manual is being finalizing that provides guidance to fiscal agents and subcontracting agencies in the administration of the Consortia Program. Consortia staff will be available to provide ongoing technical assistance as we progress through implementation of these revisions.

Direct Service Contracting

During the last quarter of Year 09, seven counties underwent a disbanding of their HIV Care Consortia. Of primary importance was the provision of HIV services to the persons living with HIV/AIDS in these impacted counties; this was addressed through implementation of the Direct Services pilot. HRSA approved utilization of the Direct Services category of the CARE Act, which allows states to directly fund services in the absence of a consortium or when this approach is proven to be more beneficial to the delivery of services. Under this pilot, the OA directly contracted with local fiscal agents that provide or subcontract HIV services. Fiscal agents are solely responsible for the completion of planning documents and other documents typically required of consortia. Though not required under the Direct Services category, the OA values the importance of public input in development of local care plans and mandated that each fiscal agent periodically convene an advisory group to assist in the development of planning documents, as needed.

The Direct Services Pilot Program is currently being evaluated, and to date has proven to be an efficient model in the absence of a consortium, or for consortia that are unable to complete assigned tasks, such as the development of needs and other planning documents.

To limit administrative burden and expenses, Tier A counties may utilize the Direct Services approach to the delivery of HIV services in Year 11. During Year 11, the OA will complete evaluation of this model and determine if this model will be offered to the balance of the state's HIV Care Consortia Program. Non-EMA multi-county regions that include Tier A counties are provided the option to utilize the Direct Services or Consortia model.

Resource Allocation

Funding for the Consortia Program has been allocated to counties on a formula basis, which is based primarily upon the total persons living with AIDS in each county. The allocations have also been subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The CHPG makes recommendations to the OA regarding the process for allocating Consortia Program funds. The CHPG recently determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. The allocation process has created funding imbalances and has not kept pace with the needs of counties experiencing dramatic increases in service needs. The CHPG recommended that, due to these imbalances and HRSA's emphasis on access to HIV services, the allocation process be revised.

Revised Approach to Resource Allocation

The OA accepted CHPG's recommendation to develop a tiered approach to the allocation of Consortia Program resources. This revision will be phased in throughout program Years 11 and 12. Of particular importance to creation of this model was the need to determine the number of persons accessing services in each county. AIDS Drug Assistance Program and Medi-Cal data, which provided the number of persons per county accessing those two programs for HIV medications, were considered to be the most reliable indicators currently available for determining the number of eligible persons accessing HIV services in each county.

Revision No. 1:

OA will use the existing formula, but will implement the CHPG recommendation to remove the PLWA numbers representing the incarcerated population (primarily the population residing in state correctional facilities) from the data representing the total PLWA per county. These data are collected and reported to the Centers for Disease Control and Prevention, but will not be utilized in allocating Consortia Program funding.

Revision No. 2:

The OA has developed a phased, two-year approach to revising the resource allocation process that is based upon the number of persons served, the number of PLWA and HIV funding sources available per county. This tiered approach will address funding imbalances by providing decreased funding to counties with lower service needs (Tier A), while redirecting funds to the counties with increasing service unmet need (Tier B).

Tier A allocations:

Tier A counties will receive a Year 11 allocation based upon the higher of the following:

- a) statewide HIV funding average per capita (\$4175)
- b) formula allocation (not subject to 95 percent hold harmless)
- c) established Year 11 floor of \$30,000

Tier A counties will receive a Year 12 allocated based upon the higher of the following:

- a) statewide HIV funding average per capita (to be determined)
- b) formula allocation (not subject to 95 percent hold harmless)
- c) established Year 12 floor of \$15,000

Tier B allocations:

Tier B counties will receive an allocation based upon the formula.

In addition, Tier B counties will receive a pro rata augmentation of Consortia Program funds in Program Years 11 and 12.

Tier C allocations:

Tier C counties will receive an allocation based upon the formula.

Based upon CHPG's recommendation, the OA is implementing a two-year funding allocation process based upon HIV service needs in each county. Client level data provides a clear overview of local service needs and allows for the allocation of Consortia Program funding to be equitably based upon this need.

Please do not hesitate to contact your Consortia Liaison to discuss these program and fiscal changes.

Thank you for your ongoing commitment to the provision of HIV services in California.

Sincerely,

Peg Taylor, Chief
CARE Section
Office of AIDS

Consortia Liaisons:

Jeff Byers
(916) 327-6804

Liz Voelkert
(916) 327-6792

Leona Lucchetti
(916) 445-1180

Cynthia Garey
(916) 324-1611

DEPARTMENT OF HEALTH SERVICES

601 North 7th St.
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 323-8949

**OFFICE OF AIDS
HIV Care Consortia****Management Memorandum
Memorandum Number: 01-02****To: Title II Fiscal Agents****Date: January 12, 2001****Subject**Ryan White CARE Act Application 2001-02 (Year 11)

Enclosed is the Ryan White CARE Act Application for Fiscal Year 2001-02 and the Technical Assistance Manual.

HRSA Emphasis

The fiscal year 2001 grant application guidance received by the Office of AIDS from the Health Services and Resources Administration (HRSA) identified several areas of emphasis. They are:

- Continue to develop systems that support 100% access to medical treatment and 0% disparity in health outcomes among under-served and emerging populations.
- Ensure that primary medical care is available to all individuals.
- Increase efforts to bring infected individuals not in care, into care.
- Provide outcome evaluation data to HRSA to meet legislative requirements and provide states with data about service effectiveness.
- Clearly indicate how support services help individuals access or maintain participation in primary medical care.

**Service Category
Changes**

To achieve the above emphasis, HRSA added, changed or deleted several service categories. In brief, major changes include:

- Primary medical care has been defined to include care that is consistent with Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
- Chiropractic and acupuncture treatments can be provided when approved in writing by an individual's primary care physician.
- All other "complimentary therapies" are no longer allowable, including massage, Chinese herbs, etc.

Continued next page

- Case management services have been moved from “health services” to “support services.” Additionally there is increased need to differentiate among case management, client advocacy and referral services.
 - A new category of “HIV/AIDS Treatment Adherence” is created; guidance for this category has not been received from HRSA.
-

**Housing and Utility
Assistance
Coordination
Between RWCA and
HOPWA**

Ryan White Title II funds for housing assistance are restricted as stated below; the Housing Opportunities for People With AIDS program (HOPWA) does **not** contain these restrictions.

- Only short term or emergency housing is allowable;
- Housing assistance must meet the “payor of last resort” test;
- CARE assistance cannot be for permanent housing. Short term housing assistance must include a plan to identify, locate, and ensure that the family is moved to permanent housing; and
- Housing assistance must be linked to medical and/or supportive services or be certified as essential to a client’s ability to gain or maintain access to HIV–related medical care or treatment.

This year, HOPWA will be making a concerted effort to spend the maximum amount of funding possible for direct housing and utility costs. Housing related services provided by Ryan White Title II must be evaluated to determine what portion of the services could be paid using HOPWA funds versus Ryan White Title II funds. Expenditures that may require extensive documentation and/or justification under Ryan White Title II are routine under HOPWA. It is imperative that you evaluate these issues when developing your Ryan White Title II application. Once evaluated, shift services to HOPWA or Ryan White as appropriate.

Review your proposed service categories to determine:

- The amount of staff costs currently paid with HOPWA funds which could be paid for by Ryan White Title II.
 - Direct housing services allocated under Ryan White Title II which could be paid for with HOPWA funds.
 - That coordinated planning efforts for these (and other) housing funding sources exist.
-

Continued next page

**Office of AIDS
Activities**

To help the State and Consortia support HRSA's goals, the Office of AIDS took several steps during the past years, including:

- Provided goals and objectives to the consortium to facilitate their movement towards the goals of 100% access/0% disparity.
 - Provided to fiscal agents, consortia members, service providers and OA office staff training in unit costing and outcome evaluation, which are required activities.
 - Streamlined the annual application where possible.
 - Provided technical assistance to individual Consortia as requested.
 - Created a direct contract option for counties whose Consortia disbanded.
 - Released low-impact counties from administrative requirements where possible.
 - Increased technical assistance to high-impact counties.
-

**2001 – 2002
Application**

The reauthorized Ryan White CARE Act contains numerous revisions and clarifications regarding the utilization of Title II funds, many of which require program and administrative revisions at the state and local levels. The OA has begun development of a preliminary implementation plan for addressing and meeting HRSA's goals and objectives; many of the program revisions contained within this application are a direct outcome of the OA's implementation plan.

A simplified application process for Year 11 has been created. The initial application submittals are minimal, and include primarily budget and administrative documents and certifications. A follow-up submittal will detail local efforts being planned for addressing HRSA's emphasis on increasing access to medical treatment and decreasing disparities in health outcomes.

Consortia and Direct Services Contractors must utilize this time to restructure their activities and programs to reflect HRSA's emphasis on increasing access to medical treatment and decreasing disparities in health outcomes. Services funded by Ryan White Title II in Year 11 (FY 2001/02) must be necessary for clients to access or maintain access to primary medical care. The plans you developed to identify and bring under-represented populations into service will be critical to meeting HRSA's goals. If you need technical assistance in refining your plans, including identifying populations, please contact your liaison.

Continued next page

Allocations

Due to the Act's reauthorization and recent political events, HRSA has not received confirmation on the funding allocations for the coming year. You will be notified as soon as possible as to the amount of funding for fiscal year 2001-02.

Peg Taylor, Chief
CARE Section

Consortia Liaisons:

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DEPARTMENT OF HEALTH SERVICES

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**OFFICE OF AIDS
HIV Care Consortia****Management Memorandum
Memorandum Number: 01-03****to:** Title I Contacts for Title II Contracts**DATE:** January 11, 2001

Topic	<u>Consortia Program Application for Fiscal Year 2001- 2002 (Year 11)</u>
Summary	<p>Attached is the Consortia Program Application for Fiscal Year 2001 - 2002. We incorporated new elements based upon information received from the Department of Health and Human Services (HRSA) HIV/AIDS Bureau (HAB) and subsequently made changes in the narrative portion and in the fiscal documents.</p> <p>To apply for Ryan White Title II Care Act Consortia Funds, complete the attached checklist, fiscal documents and attach a copy of your 2001 Title I Formula/ Supplemental application that was submitted to HRSA in September, 2000.</p>
Due Date	<u>Complete and submit your application no later than Wednesday, February 8, close of business. FAX copies will not be accepted.</u>

Peg Taylor, Chief
CARE Section

Consortia Liaisons:

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DEPARTMENT OF HEALTH SERVICES**OFFICE OF AIDS****611 NORTH SEVENTH STREET, SUITE A
SACRAMENTO, CA 95814-0208****OFFICE OF AIDS
HIV Care Consortia****Management Memorandum
Memorandum Number: 01-05****TO: Consortia Program Fiscal Agents****DATE: March 16, 2001****Topic Consortia Program Allocation for Fiscal Year 2001- 2002 (Year 11)****Summary**

Enclosed is the Consortia Program Allocation Table for Program Year 11 (Fiscal Year 2001/2002), dated March 14, 2001. In reviewing the allocation information, please note the following:

Funding Decreases: The Year 11 Consortia Program allocation has been reduced by \$459,069. This funding decrease impacted the State's Title II allocation and was the result of new provisions of the reauthorized Ryan White CARE Act (RWCA), to include a set-aside earmarked nationally for emerging communities. California joins 31 other states that experienced substantial funding decreases in their Title II allocations. Most non-Tier A counties were not impacted by this decrease due to the 95% hold harmless provision of the Consortia Program resource allocation process.

Resource Allocation Revision: The Tiered Approach to resource allocation has been fully implemented, with additional funds being redirected to the highly impacted Tier B counties. (See Management Memo 01-01 for detailed description of this change to the resource allocation process.)

Minimum Allocations to Women, Infants, Children and Youth: Please note that the allocation table does not include specific requirements for Women, Infants and Children (WIC), which has been the practice in past years. The RWCA WIC mandate has been expanded to include Women, Infants, Children and Youth (WICY), and requires that funds be allocated and expenditures tracked separately for each of these four categories. The RWCA also includes language that allows state grantees to request a waiver to all or part of this requirement.

Health Resources Services Administration has not provided guidance for Title II grantees regarding the WICY requirements and the process for requesting a waiver. Until the Office of AIDS receives guidance and is able to provide clear instruction to fiscal agents regarding this requirement, fiscal agents and service providers must document expenditures for clients that fall into one of these categories for future reporting purposes. It is anticipated that guidance regarding this requirement will be made available within the next 60-days.

Your Consortia Liaison will be in contact with you regarding the revisions to your Consortia Program budget documents that may be required as a result of this allocation information.

The unforeseen delays in receiving the Title II allocation has created an administrative nightmare for all parties involved. The staff of the Consortia Program is determined to do everything possible to ensure that the clients do not experience a lapse in service delivery due to this delay.

If we can be of assistance to you, please do not hesitate to contact your Consortia Liaison or the Consortia Program Fiscal Analyst, Stella Kile at (916) 327-6771.

Peg Taylor, Chief
CARE Section

Enclosure

Consortia Liaisons:

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**OFFICE OF AIDS
HIV Care Consortia****Management Memorandum
Memorandum Number: MM02-01**

To: Title II Fiscal Agents **Date:** January 19, 2002

Subject: Consortia Program Guidance and Technical Assistance
Manual, and Intent to Provide Services

Summary: The above listed documents are electronically attached to this management memorandum. These documents provide you with information to prepare and submit the components of your Consortia Program or Direct Services Contract program application for FY 2002 – 2003. You may submit all documents via email except those that require signatures. The budget documents have been re-formatted in Excel and self-total. If you have any questions regarding these documents, please contact your assigned consortia liaison.

The Health Resources and Services Administration (HRSA) has not released information regarding California's Title II Program allocation. We will notify you as soon as possible once we receive the Consortia Program allocation.

To the extent possible please allocate funds for consortia member training and travel. Based on input from the Consortia Model Focus Group, we are developing training and meeting opportunities. We have a limited budget for training and the Office of AIDS cannot compensate all consortia activity costs. Our hope is to provide regional trainings to lower training costs. We will provide information on training and meetings as they are developed.

Action Required Please file this management memorandum in your Consortia Administrative Manual.

Peg Taylor, Chief
CARE Section

Consortia Liaisons:

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**OFFICE OF AIDS
HIV Care Consortia****Management Memorandum
Memorandum Number: 02-03**

To: Title II Fiscal Agents **Date:** March 7, 2002

Subject: Consortia Program Changes and Meeting

**Consortia
Program
Changes**

California uses the HIV Care Consortia funding category of the Ryan White CARE Act to provide Title II funds for the coordination, planning and provision of HIV services. Over the past two years, several counties' consortia disbanded and others expressed concerns with consortia program requirements. We developed a pilot project using the Direct Services category to fund health and support services for the counties with no consortia. Based on the Pilot Project evaluation and recommendations from fiscal agents, consumers, community members and service providers, consortia program staff developed an alternative model to the consortia. The attached "Care Services Program" document describes this process and the new planning model.

Tier A stand-alone county requirements are not changed, however, Tier A fiscal agents should be familiar with the changes because tier status can change based on client population.

Meeting

The meeting on March 27 and 28 will:

- Explain the new model requirements and provide an opportunity for you to discuss the changes with other fiscal agents;
- Include information on creating linkages with Title III and IV projects; and,
- Provide training on "Creating Linkages Within Your Community", presented by Alice Gandelman, Director, CA STD/HIV Prevention Training Center and Paul Gibson, Director, Chlamydia Awareness Prevention Project.

**Action
Required**

Please:

- Complete and return the fax document if you will be attending the meeting;
- Review the "Care Services Program" document prior to the meeting.
- File this management memorandum in your Consortia Administrative Manual and forward a copy to your service providers.



OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-05

**TO: CARE SERVICES PROGRAM
FISCAL AGENTS**

DATE: March 28, 2002

Topic Care Services Program Allocation for Fiscal Year 2002 (Year 12)

Enclosed is the Care Services Program Allocation Table for Program Year 12 (Fiscal Year 2002/03), dated March 28, 2002. In reviewing the allocation information, please note the following:

**Resource
Allocation
Process**

Funding for the Care Services Program has been allocated to counties on a formula basis, which is based primarily upon the total persons living with AIDS in each county. The allocations have also been subject to a 95 percent hold harmless provision that was developed to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The Resource Allocation Committee of the statewide California HIV Planning Group (CHPG) makes recommendations to the Office of AIDS (OA) regarding the process for allocation Care Services Program funds. The CHPG recently determined that certain counties have experienced dramatic increases in the number of clients served, while disproportionately larger allocations have been made to counties with relatively few clients. A tiered allocation process was created, upon recommendation of the CHPG, to address these imbalances over a two year period by redirecting funding to the counties with the highest need.

**Resource
Allocation
Revision**

The Tiered Approach to resource allocation has been fully implemented (see Management Memo 01-01). Adjustments have been made to lower the funding available to existing Tier A counties and a redirection of additional funding to the highly impacted Tier B counties.



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Tier A counties:

Alpine
Colusa
Modoc
Mono
Sierra

Tier B counties:

Fresno
Kern
San Joaquin
San Luis Obispo
Stanislaus

The 95 percent hold harmless provision is still in effect and was equally applied, with the exception of existing Tier A counties.

**Minimum
Allocations
to Women,
Infants,
Children,
and Youth**

Please note that the allocation table does not include specific requirements for Women, Infants, and Children (WIC), which has been the practice in past years. The WIC mandate was expanded in Year 11 to include Women, Infants, Children, and Youth, and requires that funds be allocated and expenditures tracked separately for each of these four categories. The Ryan White CARE Act also includes language that allows state grantees to request a waiver to all or part of this requirement. It is anticipated that the OA will request a waiver to one or all of these categories.

Thank you for your patience with the Year 12 allocation process. Our receipt of the Title II allocation information from Health Resources Services Administration was delayed, and our process for developing the final allocation was further delayed due to unforeseen problems in receiving data.

If we can be of assistance to you, please do not hesitate to contact your Care Services Program Advisor or the Care Services Program Fiscal Analyst, Stella Kile at (916) 327-6771.

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosure

Care Services Program Advisors:

Barbara Weiss	Liz Voelkert	Leona Lucchetti	Cynthia Garey	Stella Kile
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OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-06

DATE:

TO: CARE SERVICES PROGRAM FISCAL AGENTS

**SUBJECT: YEAR 12 CARE SERVICES PROGRAM APPLICATION DOCUMENTS AND
REVISED AGREEMENTS AND ASSURANCES FORM**

Summary

Management Memo 02-05, e-mailed to you on Friday, March 29, 2002, contained the Year 12 Care Services Program Allocation Table. A hard copy of Management Memo 02-05 is being mailed to you.

Enclosed is the revised Agreements and Assurances form, which reflects the new Care Services Program model (Title I grantees do not need to complete this form).

In order to process your contract amendment and ensure ongoing payment for services, please submit all required application documents by the date noted below.

**Due Date/
Questions**

Please submit the Year 12 application documents to your Care Services Advisor on or before **April 19, 2002**. If you have any questions, please contact your Care Services Advisor.

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosures



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OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-07

DATE:

TO: NON-EMA CARE SERVICES PROGRAM FISCAL AGENTS

SUBJECT: ADDITIONAL INFORMATION FOLLOWING THE MARCH 27, 2002 NEW MODEL MEETING

Summary

Enclosed are several pieces of information requested at the March 27, 2002.

New Model meeting at the Office of AIDS. The information includes:

- DHS Office of Legal Services decision regarding the FPPC Form 700 and the Brown Act
- Definition of “consult with”
- Transition Plan information and forms
- List of barriers identified by infected/affected community members at the focus group held in October 2002 to discuss the consortia model
- Peg Taylor’s power point presentation of the new Care Services Program model

Due Date

The transition plan is due to your Care Services Program Advisor by **July 1, 2002.**

Questions

Please contact your Care Services Program Advisor if you have any questions.



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www.consumerenergycenter.org/flex/index.html

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosures



OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 02-08

DATE:

TO: ALL CARE SERVICES PROGRAM FISCAL AGENTS

SUBJECT: NEW MILEAGE REIMBURSEMENT RATE

Summary

The State of California mileage reimbursement rate has increased from \$.31 per mile to \$.34 per mile. Effective April 1, 2002, mileage will be reimbursed up to \$.34 per mile.

**Action
Required**

Please file this Management Memorandum in your Program Administrative Manual.

Questions

Please contact your Care Services Program Advisor if you have any questions.

Peg Taylor, Chief
CARE Section
Office of AIDS



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www.consumerenergycenter.org/flex/index.html

**Summary:
(continued)**

You may choose from one of the following software options to submit your data:

- The Ryan White CAREWare (The CAREWare technical support contact number is 1-877-294-3571. The software is free.),
- The CMP/Care Services Database (free software), or
- Your current data collection system provided that it meets HRSA's export format specifications for submitting client-level data. (If you want to use your current in-house system, please contact Ms. Denise Absher at (916) 322-3150 for system requirements.)

Please contact Ms. Denise Absher if you would like to receive a copy of the CAREWare or if you would like to schedule CAREWare training. More information will be distributed as the new contract year approaches.

**Action
Required:**

Please file this management memorandum in your Administrative Manual and forward a copy to your service providers.

Peg Taylor, Chief
CARE Section
Office of AIDS

cc: See Next Page

Consortia Liaisons:

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**OFFICE OF AIDS
Care Services Program**

**Management Memorandum
Memorandum Number: 02-09**

DATE:

TO: TITLE II FISCAL AGENTS

SUBJECT: NEW DATA REPORTING REQUIREMENTS

Topic: Health Resources Services Administration (HRSA) requires that the Care Services Program (CSP) annually report aggregate-level data provided by Title II funded agencies (CARE Act Data Report). This type of data collection does not allow the CSP to follow clients and services across providers, counties, or service areas.

Summary: Beginning April 1, 2003, providers will be required to collect and report client-level data. Client name and other identifying information should not be reported to the Office of AIDS (OA). Client-level data reporting overcomes the limitations of the CARE Act Data Report which collects aggregate level data. Client-level data helps the OA monitor health outcomes and service utilization patterns, and ensures the accuracy and usefulness of Care Services Program data. The First Quarter Report (April 1, 2003 through June 30, 2003) is due to the OA on July 31, 2003.



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www.consumerenergycenter.org/flex/index.html

**Summary:
(continued)**

You may choose from one of the following software options to submit your data:

- The Ryan White CAREWare (The CAREWare technical support contact number is 1-877-294-3571. The software is free.),
- The CMP/Care Services Database (free software), or
- Your current data collection system provided that it meets HRSA's export format specifications for submitting client-level data. (If you want to use your current in-house system, please contact Ms. Denise Absher at (916) 322-3150 for system requirements.)

Please contact Ms. Denise Absher if you would like to receive a copy of the CAREWare or if you would like to schedule CAREWare training. More information will be distributed as the new contract year approaches.

**Action
Required:**

Please file this management memorandum in your Administrative Manual and forward a copy to your service providers.

Peg Taylor, Chief
CARE Section
Office of AIDS

cc: See Next Page

Consortia Liaisons:

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cc: Ms. Stella Kile
CARE Section
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Department of Health Services
611 North Seventh Street, Suite A
Sacramento, CA 95814-0208

Ms. Denise Absher
Care Research and Evaluation Section
Office of AIDS
Department of Health Services
611 North Seventh Street, Suite A
Sacramento, CA 95814-0208

California—Health and Human Services Agency
Department of Health Services



GRAY DAVIS
Governor

**OFFICE OF AIDS
HIV Care Consortia**

**Management Memorandum
Memorandum Number: 03-01**

TO: TITLE II FISCAL AGENTS

SUBJECT: TECHNICAL ASSISTANCE GUIDE FOR SERVICE DELIVERY PLANS

Summary: Enclosed is a Technical Assistance Guide for developing a Service Delivery Plan for your county or region. The original due date of July 1, 2003, has been extended to December 1, 2003.

Approved Service Delivery Plans will be in effect for three years. Updates will be submitted as necessary, and will, in effect, replace much of your future Care Services Program applications (with the exception, of course, of budget and other documents required by Health Resources Services Administration (HRSA) and for completion of the Standard Agreement document).

**Why Are We
Required To
Do This?**

Accountability! HRSA is adamant in stressing the point that grantees are responsible to account for the funds they receive. Deborah Parham, Director of HRSA states, "...The grantees are accountable to us; we are accountable to Congress; Congress is accountable to the taxpayers."

Additionally, a Service Delivery Plan provides a "road map" for the development of a system of care and a blueprint for the complex decisions that must be made about planning, developing and delivering comprehensive HIV services in your community. With the current and



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www.consumerenergycenter.org/flex/index.html

ongoing budget difficulties, along with an ever-increasing number of clients, many difficult planning and programmatic decisions will probably have to be made in the next few years. Our hope is that the development of plans will assist in making these decisions.

What is the Office of AIDS Doing?

HRSA mandated that the Office of AIDS (OA) develop a Statewide Comprehensive Plan for HIV Services. The Comprehensive Plan is a framework for the continued development and improvement of California's comprehensive service delivery model over the course of several years. The plan includes a series of principles, goals and strategies for implementation by all programs within the HIV Care Branch of the OA.

A coalition of HIV positive individuals, care providers, administrators and OA staff worked together to develop this plan. When the plan is fully approved, a copy will be provided to you.

What Does the State's Comprehensive Plan for HIV Services Mean to Me?

In addition to providing an overview of California's epidemic and service delivery, the plan includes the state's vision for delivery of HIV care and treatment and services, and goals and objectives for programs contained within the HIV Care Branch of the OA. The Care Services Program identified goals that will be addressed over the next three years. These goals are outlined in the enclosed technical assistance guide.

Fiscal agents, as a component of the multi-year Service Delivery Plans, will develop goals and objectives to support each of the five goals identified in the plan. You will report progress made in achieving your goals and objectives in the mid-year and year-end reports. The OA will then take the information you provide and report progress made to HRSA.

Technical Assistance

The OA will be sponsoring regional technical assistance meetings in May or June 2003 that will address the Service Delivery Plan. Specific information on dates and locations will follow.

Required Action

- Review the Technical Assistance Guide for developing a Service Delivery Plan.
 - If you have any questions or require technical assistance, please contact your Care Services Advisor.
 - Submit your Service Delivery Plan to your Care Services Advisor by **December 1, 2003**.
-

Peg Taylor, Chief
CARE Section

CARE Service Advisors:

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Cynthia Garey
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bcc: Ms. Eileen Harvey
CARE Program Analyst
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Office of AIDS
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**TITLE II CARE SERVICES PROGRAM ALLOCATIONS
YEAR 13**

County	YR12 Allocation	YR13 Allocation
Alameda	\$445,573	\$450,375
Alpine	\$15,000	\$15,000
Amador	\$51,561	\$48,983
Butte	\$75,402	\$71,631
Calaveras	\$44,724	\$42,488
Colusa	\$15,000	\$15,000
Contra Costa	\$148,445	\$174,593
Del Norte	\$42,743	\$40,606
El Dorado	\$106,096	\$100,791
Fresno	\$371,181	\$352,622
Glenn	\$51,310	\$48,744
Humboldt	\$89,961	\$85,463
Imperial	\$73,056	\$69,403
Inyo	\$42,743	\$40,606
Kern	\$277,875	\$263,981
Kings	\$72,431	\$68,809
Lake	\$67,281	\$63,917
Lassen	\$41,988	\$39,889
Los Angeles	\$2,833,812	\$2,978,589
Madera	\$77,616	\$73,735
Marin	\$104,055	\$98,853
Mariposa	\$40,607	\$38,576
Mendocino	\$87,412	\$83,042
Merced	\$101,228	\$96,167
Modoc	\$15,875	\$15,081
Mono	\$15,000	\$15,000
Monterey	\$194,224	\$184,513
Napa	\$45,710	\$43,425
Nevada	\$87,140	\$82,783
Orange	\$619,570	\$627,887
Placer	\$81,418	\$77,347
Plumas	\$42,743	\$40,606
Riverside	\$443,329	\$504,935

Sacramento	\$416,761	\$395,923
San Benito	\$44,102	\$41,897
San Bernardino	\$293,678	\$314,366
San Diego	\$785,943	\$850,806
San Francisco	\$1,279,200	\$1,215,240
San Joaquin	\$217,031	\$206,179
San Luis Obsipo	\$119,056	\$113,103
San Mateo	\$140,506	\$133,481
Santa Barbara	\$143,134	\$135,977
Santa Clara	\$466,363	\$443,044
Santa Cruz	\$117,771	\$111,882
Shasta	\$86,382	\$82,063
Sierra	\$15,000	\$15,000
Siskiyou	\$42,066	\$39,963
Solano	\$196,677	\$186,843
Sonoma	\$286,503	\$272,178
Stanislaus	\$165,602	\$157,322
Sutter	\$40,607	\$38,576
Tehama	\$48,584	\$46,155
Trinity	\$40,607	\$38,576
Tulare	\$185,502	\$176,227
Tuolumne	\$55,139	\$52,382
Ventura	\$148,604	\$141,174
Yolo	\$56,817	\$53,976
Yuba	\$40,607	\$38,576
TOTAL	\$12,254,349	\$12,254,349

NOTE: Final allocations are subject to the state budget process, currently underway, and are subject to revision.

OFFICE OF AIDS
Care Services Program

Management Memorandum
Memorandum Number: 03-02

**TO: CARE SERVICES PROGRAM
FISCAL AGENTS**

Date: April 17, 2003

Topic: Care Services Program Allocation for Fiscal Year 2003 (Year 13)

Enclosed is the Care Services Program Allocation Table for Program Year 13 (Fiscal Year 2003/04), dated April 17, 2003.

**Resource
Allocation
Process**

Funding for the Care Services Program is allocated to counties on a formula basis (see methodology - Attachment A). The allocations have also been subject to the 95 percent hold harmless provision that was developed many years ago to protect counties from receiving large funding decreases resulting solely through utilization of the formula.

The Tiered Approach has been fully implemented and has accomplished a redirection of Care Services Program funding among low- and moderately-impacted counties. Those counties determined in Year 12 to be Tier A counties will continue to receive the floor funding amount, while all remaining counties are subject to the formula allocation process.

The existing formula allocation process will continue to be utilized until HIV and client utilization data is made available through California's HIV reporting system and the reporting of client level data. At that time, an advisory group will be convened to work with the OA to provide input and recommendations regarding the allocation of Title II Care Services Program resources.

**Minimum
Allocations
to Women,
Infants,
Children,
and Youth**

Please note that the Ryan White CARE Act includes specific requirements for allocation and expenditure of funding for Women, Infants, Children and Youth (WICY). The WICY mandate requires that funds be allocated and expenditures tracked separately for each of these four categories. Please make arrangements to track your expenditures to each of these categories, as they mirror the epidemic in your county or region. Information about reporting requirements will be forthcoming. As a guideline, please note the following statewide percentages for these categories:

Infants: .01%
Children: .28%
Youth: .89%
Women: 10.5%

Continued next page

**Title II
Funding
Levels**

The annual allocation to the Care Services Program is provided through the Ryan White CARE Act's Title II Base allocation, which also funds other HIV programs such as CARE/HIPP, Community Based Care, Viral Load and Resistance Testing, and partially funds the AIDS Drug Assistance Program. California's Year 13 allocation for Title II Base was reduced by approximately \$1.3 million. OA has taken measures to maintain funding for all Title II programs. However, allocation decisions made through the state budget process could result in a redirection of funding among Title II programs, and a decreased allocation to the Care Services Program.

If implemented, an overall reduction in the Care Services Program allocation will result in decreased allocations to some counties. It is important to note that the 95% hold harmless provision is in effect; it is anticipated that counties receiving a Year 13 allocation equal to 95% of their Year 12 allocation will not be impacted by this revision to the allocation. Care Services Program Advisors will contact all contractors that may be subject to a reduction to discuss this matter.

The Year 13 allocation process has been, and continues to be, a particularly arduous task. The Care Services Program staff and I would like to take this opportunity to thank you for your patience and understanding. If we can be of assistance to you, please do not hesitate to contact your Care Services Program Advisor or the Care Services Program Fiscal Analyst, Stella Kile at (916) 327-6771.

Peg Taylor, Chief
CARE Section
Office of AIDS

Enclosures
Allocation Table
Attachment A

YEAR 13 TITLE II CARE SERVICES PROGRAM ALLOCATION FORMULA

The formula consists of the following components:

- X Factor 1: Number of unduplicated individuals receiving services. The number of persons *living* with AIDS utilizing the most recent two years of data available (California State Office of AIDS) is used as the indicator for this component. This factor will be weighted fifty percent (50%).
- X Factor 2: Access to care/barriers to care. This component consists of four indicators:
 - a. The number of square miles within the county (2000 Census),
 - b. Population per square mile within the county (2000 Census),
 - c. Proportion of people of color (California Department of Finance Projections, 2003),
 - d. Population of non-English speaking persons (1990 Census – this level of information was not yet available from the 2000 Census), and
 - e. Proportion of population below poverty level (2000 Census).

Each indicator will be weighted five percent (5%) so that the factor will be weighted a total of twenty-five percent (25%).

- X Factor 3: Keeping pace with the epidemic. This component is comprised of the number of *reported* cases in each county utilizing the most recent two years of data (California State Office of AIDS). This factor will be weighted twenty-five percent (25%).

Methodology

The allocation formula was run using updated data sets. The Year 13 allocation was adjusted so that no county received more than a five percent (5%) reduction from Year 12. Counties receiving less than a five- percent (5%) decrease from Year 12 received the formula allocation.

cc: Ms. Stella Kile
CARE Section
Office of AIDS
Department of Health Services
611 North Seventh Street, Suite A
Sacramento, CA 95814-0208

Ms. Denise Absher
Care Research and Evaluation Section
Office of AIDS
Department of Health Services
611 North Seventh Street, Suite A
Sacramento, CA 95814-0208

Exhibit 1

CARE Act Legislation

CARE Act legislation is accessible through the worldwide web. To access this legislation, do the following:

1. Go to: <http://thomas.loc.gov/>
2. Under "Legislation," click on "**Public Laws by Law Number.**"
3. Under "Select Congress," click on "**101.**"
4. Click on "**101-351 - 101-400.**"
5. Page down to number "381" and click on "**S.2240.**"
6. Page down to "**Text of Legislation**" and click on it.
7. Click on "**Full Display.**"

COUNTY	FISCAL AGENT
Alameda/Contra Costa	Gary Schriebman Alameda County Health Care Services Office of AIDS (510) 873-6512
Amador/Calaveras/Tuolumne	Shelly Hance Amador-Tuolumne Comm. Action Agency (559) 737-4660
Butte/Colusa/Glenn/Sutter/Yolo/Yuba	W. Jay Coughlin United Way of Butte & Glenn Counties (530) 342-7898
Fresno	Alan Gilmore Dept. of Community Health (559) 445-3324
Humboldt/Del Norte	Alexandra Wineland Humboldt County Dept. of Public Health (707) 268-2122
Imperial	Joe Picazo Imperial County Public Health (760) 339-4438
Inyo	Randi Lee Dept. of Health & Human Services of Inyo County (760) 878-0081
Kern	Donna Goins Kern County Health Dept. (661) 868-0205
Kings	Barbara Van Buren Kings County Health Dept. (559) 584-1401 x 4531
Lake	Anne McAfee Mendocino Community Health Clinic (707) 468-1010 x 122
Los Angeles County	Charles Henry County of Los Angeles – OAPP (213) 351-8001

COUNTY	FISCAL AGENT
Madera	Ann Harris Madera County Dept. of Public Health (559) 675-7627
Mendocino	Rosalie Anchordoguy Mendocino County Public Health (707) 463-4573
Merced/Mariposa	Karen Resner Merced County Dept. of Public Health (209) 381-1036
Mono	Mary Booher Mono County Health Dept. (760) 932-7485
Monterey	Wayne Johnson Monterey County AIDS Project (831) 772-8200
Napa	Dr. Robert Hill Napa County Health & Human Services (707) 253-4566
Nevada	Mary Ann Newnan Nevada County Community Health Dept. (530) 470-2420
Orange	Alice Moore Orange County Health Care Agency (714) 834-3121
Plumas/Sierra/Lassen/Modoc/ Siskiyou	Rita Scardaci County of Plumas (530) 283-6337
Sacramento/Alpine/El Dorado/ Placer	Adrienne Rogers Sacramento County Dept. of Health (916) 875-6211
San Benito	Robin Jay San Benito County Health & Human Services (831) 636-4180

COUNTY	FISCAL AGENT
San Bernardino/Riverside	Coleen Tracy San Bernardino County Dept. of Public Health (909) 387-6222
San Diego	Janice DiCroce San Diego County Health and Human Services Agency (619) 515-6679
San Francisco/Marin/San Mateo	Michelle Dixon Dept. of Public Health (415) 554-9043
San Joaquin	Geneva Bell-Sanford Public Health Services, San Joaquin County (209) 468-3891
San Luis Obispo	Nancy Rosen San Luis Obispo County Health Agency (805) 781-5518
Santa Barbara	Pam Stowe County of Santa Barbara (805) 681-5465
Santa Clara	Audrey Broner Santa Clara County Public Health Dept. (408) 885-7711
Santa Cruz	Betsy McCarty Santa Cruz County Health Services Agency (831) 454-4490
Shasta/Trinity/Tehama	Daniel Johnson Northern Valley Catholic Social Service (530) 247-3327
Solano	Peter Turner Solano County Health & Social Services Dept. (707) 553-5557
Sonoma	Patricia Kuta County of Sonoma Dept. of Health Services (707) 565-7379

COUNTY	FISCAL AGENT
Stanislaus	Patty Stone Doctors Medical Center Foundation (209) 527-3412
Tulare	Mary Beth Hash Tulare County Health & Humas Services Agency (559) 733-6123 x219
Ventura	Craig Webb Ventura Public Health (805) 677-5227

CONSORTIA LIAISON ASSIGNMENTS

<u>Jeff Byers</u> (916) 327-6804	<u>Cynthia Garey</u> (916) 324-1611	<u>Leona Lucchetti</u> (916) 445-1180	<u>Liz Voelkert</u> (916) 327-6792
Inland Empire (Riverside & San Bernardino)	Inyo	ACT 3 (Amador, Calaveras, Tuolumne)	Fresno
Los Angeles	Kern	Butte Group (Butte, Glenn, Yuba, Yolo, Sutter, Colusa)	Humboldt (includes Del Norte)
Oakland EMA (Alameda & Contra Costa)	Kings	Monterey	Imperial
Orange	Madera	Napa	Lake
Sacramento (Alpine, Placer, El Dorado, Sacramento)	Merced/Mariposa	Nevada	Mendocino
San Francisco (Marin, San Francisco, San Mateo)	Mono	Santa Cruz	Mt. Counties (Plumas, Lassen, Sierra, Modoc, Siskiyou)
Santa Clara	San Benito	Shasta/Trinity/ Tehama	San Diego
	San Joaquin	Solano	San Luis Obispo
	Stanislaus	Sonoma	Ventura
	Tulare		

CARE Act Approved Services

Health Care Services	Description
Ambulatory/Outpatient Medical Care	Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient, community-based and/or office-based setting. This includes diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with Public Health Service guidelines. Such care must include access to antiretrovirals and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
Dental Care	Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.
Drug Reimbursement Program	<p>On-going service/program to pay for approved pharmaceuticals and or medications for persons with no other payment source. Subcategories include:</p> <ul style="list-style-type: none"> a. State AIDS Drug Assistance Program (ADAP): Title II CARE Act-funded and administered program or other state-funded Drug Reimbursement Program, or b. Local/Consortia Drug Reimbursement Program: A program established, operated and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State-funded Drug Reimbursement Program. <p><i>Medications</i> include prescription drugs provided through an ADAP to prolong life or prevent the deterioration of health. The definition does not include medications that are dispensed or administered during the course of a regular medical visit, that are considered part of the services provided during that visit. If medications are an item paid for and dispensed as part of a <i>Direct Emergency Financial Assistance Program</i>, they should be reported as such.</p>

Health Care Services	Description
Health Insurance	A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program, including risk pools.
Home Health Care	<p>Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Component services include:</p> <ul style="list-style-type: none"> a. Durable medical equipment; b. Homemaker or home health aide services and personal care services; c. Day treatment or other partial hospitalization services; d. Intravenous and aerosolized drug therapy, including prescription drugs; e. Routine diagnostic testing administered in the home of the individual; and f. Appropriate mental health, developmental, and rehabilitation services. <p>Home- and community-based care does not include inpatient hospital services or nursing home and other long term care facilities.</p>
Hospice Services:	<ul style="list-style-type: none"> a. Home-Based Hospice Care : Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting. b. Residential Hospice Care : Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.
In-Patient Personnel Costs:	Within the limitations of the legislation, up to ten percent of the total award is allowable for such costs, if it has been determined by the Planning Council, that a shortage of inpatient personnel exists which has resulted in inappropriate utilization of inpatient services.
Mental Health Therapy/ Counseling	Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

Health Care Services	Description
Nutritional Counseling	Provision of nutrition education and/or counseling provided by a licensed/registered dietitian outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietitian should be provided under <i>Counseling (other)</i> . Provision of food, meals, or nutritional supplements should be reported as a part of the sub-category, <i>Food and/Home-Delivered Meals/Nutritional Supplements</i> , under support services.
Rehabilitation Care	Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.
Substance Abuse Treatment/Counseling	Provision of treatment and/or counseling and to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.
HIV/AIDS Treatment Adherence	Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.
SUPPORT SERVICES	DESCRIPTION
Adoption/Foster Care Assistance	Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.
Buddy/Companion Services	Activities provided by volunteers or peers to assist a client in performing household or personal tasks. Buddies also provide mental and social support to combat loneliness and isolation.
Case Management	A range of client-centered services that link clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family member's needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of service.

Support Services	Description
Client Advocacy	Assessment of individual need, provision of advice and assistance obtaining medical, social, community, legal, financial and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.
Counseling (Other)	Individual and/or group counseling services other than mental health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education.
Day or Respite Care	Home- or community-based non-medical assistance designed to relieve the primary care giver responsible for providing day-to-day care of client or client's child.
Direct Emergency Financial Assistance	Provision of short-term payments for transportation, food, essential utilities or medication assistance, which planning councils, Title II grantees, and consortia may allocate and which must be carefully monitored to assure limited amounts, limited use, and for limited periods of time . Expenditures must be reported under the relevant service category.
Food Bank/Home Delivered Meals/Nutritional Supplements	Provision of actual food, meals, or nutritional supplements.
Health Education/Risk Reduction	(1) Provision of information including information dissemination about medical and psychosocial support services and counseling or (2) preparation/distribution of materials in the context of medical and psychosocial support services to educate clients with HIV about methods to reduce the spread of HIV.
Housing Assistance	This is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of Title I, II and IV funds for short-term or emergency housing must be linked to medical and/or supportive services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.
Housing Related Services	Includes assessment, search, placement, and advocacy services provided by professionals who possess an extensive knowledge of local, State, and Federal housing programs and how they can be accessed.

Support Services	Description
Legal Services	Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. See also, Permanency Planning and Adoption/Foster Care.
Outreach	Programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services, not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting which will accommodate local effectiveness evaluation. Broad marketing of the availability of health care services for PLWH should be prioritized and funded as Planning Council or Consortium support activities.
Permanency Planning	The provision of social service counseling or legal counsel regarding: <ul style="list-style-type: none"> a. the drafting of wills or delegating powers of attorney; and b. the preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.
Referral	The act of directing a person to a service in person or through telephone, written, or other type of communication. Referral may be made formally from one clinical provider to another, within a case management system by professional case managers, informally through support staff or as part of an outreach program.
Transportation	Conveyance services provided to a client in order to access health care or psychosocial support services. May be provided routinely or on an emergency basis.
Other State Priorities	Non-direct services or programs, or non-administrative activities which have been determined to be a priority by the State for effective implementation of the Title II-funded programs/services. Examples include activities such as, volunteer training and coordination, capacity-building activities to improve the capacity of community-based and/or minority providers to deliver services to clients with HIV infection, quality assurance, and continuous quality improvement.

Support Services	Description
Other Support Services	Direct support services not listed above, such as translation or interpretation services.
Program Support	Activities that are not service oriented or administrative in nature, but contribute to or help to improve service delivery. Such activities may include capacity building, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service delivery patterns.

Exhibit 5

Program Policy Notices 97-01, 97-02, 97-03

www.hab.hrsa.gov/law/dsspolicies.htm

Financial Status Report

Reporting Period: _____ Contractor: _____ Contract Number: _____
Total Grant Award: _____

Service Provider (Subcontractor)	Total Contract	Expended To Date	Balance	Percentage Expended	# of Unduplicated Served	WIC Expenditures		
						Allocated	Expended	Balance
Needs Assessment								
Fiscal Agent Administrative Costs								
Total								

Dear Colleagues:

There is no question that a lack of access to high quality health care and tremendous disparities in health outcomes for many Americans are a major problem for our Nation. In recognition of this, the Health Resources and Services Administration (HRSA) has adopted a goal of "100% access, 0% disparity" for all of our programs, including the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Simply stated, this means that we are redoubling our focus on achieving access to high quality health care for all persons living with HIV/AIDS and eliminating race, gender, and geographic disparities in health outcome.

We are writing to ask you to examine your own programmatic decisions and priorities in the light of this goal. Disparities in health outcome, lack of access to quality health care, pharmaceuticals, and other necessary services which allow people to access and remain in care continue to challenge all of us fighting for the lives of people living with HIV/AIDS. This is particularly important in light of the potential benefit that can be offered by high quality care and by appropriate use of new anti-retroviral regimens. The Ryan White CARE Act provides one of the only mechanisms whereby our "100% access, 0% disparity" goal can be achieved in the face of this epidemic.

HRSA believes it is essential, therefore, that services supported with CARE Act funds relate to this goal. In particular, social and support services should be designed to assist persons living with HIV/AIDS to overcome barriers to accessing and to sustain participation in health care services. We urge that services which do not meet this criteria not be prioritized for CARE Act funding.

We recognize that difficult decisions are made at all levels of the CARE Act program every day and we do not presume to know what exact package of services will best serve your particular community. Communities will ultimately decide for themselves how best to achieve "100% access and 0" disparities" for people living with HIV/AIDS. This request that you partner with us and examine your own efforts in light of HRSA's goals is intended, rather, to provide direction for local processes, focus program management, and to articulate a national context for the Ryan White Program. We stand prepared to offer technical assistance and support as you address these issues and intend to devote a considerable portion of our upcoming All Title meeting to these issues.

We look forward to strengthening our partnership with you to better meet our goal of "100% access, 0% disparities" for our most vulnerable citizens.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Administrator

Exhibit 10

Sample AAR Forms and Instructions to Complete

To obtain sample AAR forms and instructions on how to complete these forms, please contact Denise Absher, at (916) 322-3150.

INVOICE DETAIL

Contractor: Name _____

Contract No. _____

Address _____

County _____

Fiscal Agent _____

Service Period: Mo. _____ Yr. ____

Contact Person _____

Provided Services HRSA Categories	Total Allocated	Expenditures To Date	Expenditures Current Month	Balance Remaining
Home Health Care				\$ -
Direct Emergency Financial Assist.				\$ -
Food Bank / Home Delivered Meals				\$ -
Housing Assistance (short Term)				\$ -
Transportation				\$ -
				\$ -
Delivery Operations:				\$ -
Administrative				\$ -
Indirect/Operational/Equipment				\$ -
				\$ -
				\$ -
FISCAL AGENT COSTS:				\$ -
Administrative				\$ -
Operating Expenses				\$ -
Capitol Expenses				\$ -
Indirect Costs				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
TOTAL	\$ -	\$ -	\$ -	\$ -

TITLE II CONSORTIUM INVOICE

Contractor Name / Fiscal Agent

Consortium Name

Mailing Address

Contract Number

Month of Service

Budgeted Categories	Contracted Amount	Amount Invoiced To Date	Amount Invoiced This Month	Remaining Contract Amount
A. PERSONNEL				\$ -
B. OPERATING EXPENSES				\$ -
C, CAPITAL EXPENDITURES				\$ -
D. OTHER COSTS				\$ -
E. INDIRECT COSTS				\$ -
TOTAL	\$ -	\$ -	\$ -	\$ -
LESS ADVANCE PAYMENT (if applicable)				\$ -
TOTAL AMOUNT PAYABLE	\$ -	\$ -	\$ -	\$ -

I hereby certify that the amount claimed is accurate and a true representation of the amount owed.

Date

Authorized Signature

Title

Department of Health Services
Office of AIDS
P.O. Box 942732
Sacramento, Ca. 94234-7320

INVOICE DETAIL

Contractor: Name _____
Address _____
City _____

Contract No. _____

County _____

Fiscal Agent _____

Service Period: Mo. _____ Yr. ____

Contact Person _____

Provided Services HRSA Categories	Total Allocated	Expenditures To Date	Expenditures Current Month	Balance Remaining
Home Health Care				\$ -
Direct Emergency Financial Assist.				\$ -
Food Bank / Home Delivered Meals				\$ -
Housing Assistance (short Term)				\$ -
Transportation				\$ -
				\$ -
Delivery Operations:				\$ -
Administrative				\$ -
Indirect/Operational/Equipment				\$ -
				\$ -
				\$ -
FISCAL AGENT COSTS:				\$ -
Administrative				\$ -
Operating Expenses				\$ -
Capitol Expenses				\$ -
Indirect Costs				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
				\$ -
TOTAL	\$ -	\$ -	\$ -	\$ -

Exhibit 11

Fact Sheet

<http://www.hab.hrsa.gov/B/factsheets/title2-1.htm>

The following table is an overview of the activities conducted during the year by the Office of AIDS, Fiscal Agent, and Consortia.

April 01: Consortia begins needs assessment process <ul style="list-style-type: none"> • Reviews past year's needs assessment 20: OA compiles final previous year's expenditure information for submittal to HRSA 20: OA compiles final current year's subcontractor budget allocation data for submittal to HRSA	May 01: Consortia continues needs assessment process <ul style="list-style-type: none"> • Determines who will conduct • Determines how it will be conducted • Revises tools as needed 	June 01: Consortia conducts needs assessment 15: OA gathering current year's contractor certifications and budget exhibits for submittal to HRSA 30: Deadline for submittal of year-end report (report period 10/ 1 – 3/ 31) 30: Deadline for submittal of final invoice
July 01: Consortia develops criteria for resource allocation	August 01: Consortia tabulates needs assessment data	September 01 Through November 30: Consortia: <ul style="list-style-type: none"> • Prioritizes data received from needs assessment • Determines allocation to service categories • Establishes a service delivery plan • Provides information to fiscal agent

<p>October</p> <p>TBA: Distribution by HRSA of next year's Title II Application to State</p>	<p>November</p> <p>17: Deadline for submittal to OA of current year's expenditure information and request for funding augmentation through reallocation process</p> <p>15: Deadline for submittal of mid-year report (report period 4/ 1 – 9/ 30)</p> <p>30: OA's distribution of Title II Consortia Program Application to current fiscal agents</p> <p>November (continued)</p> <p>30: Consortia provides prioritized list of service categories and service delivery plan to fiscal agent</p>	<p>December</p> <p>01 through January 20: Fiscal agent prepares and conducts selection of service providers (RFP process)</p> <p>04: Announcement of augmentation awards</p> <p>TBA: Deadline for OA's submittal of State Title II Program Application to HRSA</p>
<p>January</p> <p>02: Fiscal agent and consortia begin writing Annual Ryan White Application to State Office of AIDS</p> <p>20: Fiscal agent completes selection of service providers</p>	<p>February</p> <p>TBA: Submit completed annual Ryan White Application to OA</p> <p>15: Deadline for submittal to OA of AAR Calendar Year Report – reporting period 1/ 1 – 12/ 31</p>	<p>March</p> <p>05: Fiscal Agents to receive written responses from OA regarding status of Title II Consortia Application</p> <p>20: Consortia evaluates:</p> <ul style="list-style-type: none"> • Their success in responding to service needs • How the consortia functions <p>31: Deadline for submittal of Consortia Program information and documents in response to OA letter</p> <p>31: Deadline for incurring expenses under Year 10 contracts</p>

Exhibit 13

Contract Between OA and Fiscal Agent

Please refer to your individual contract that you have with the Office of AIDS.